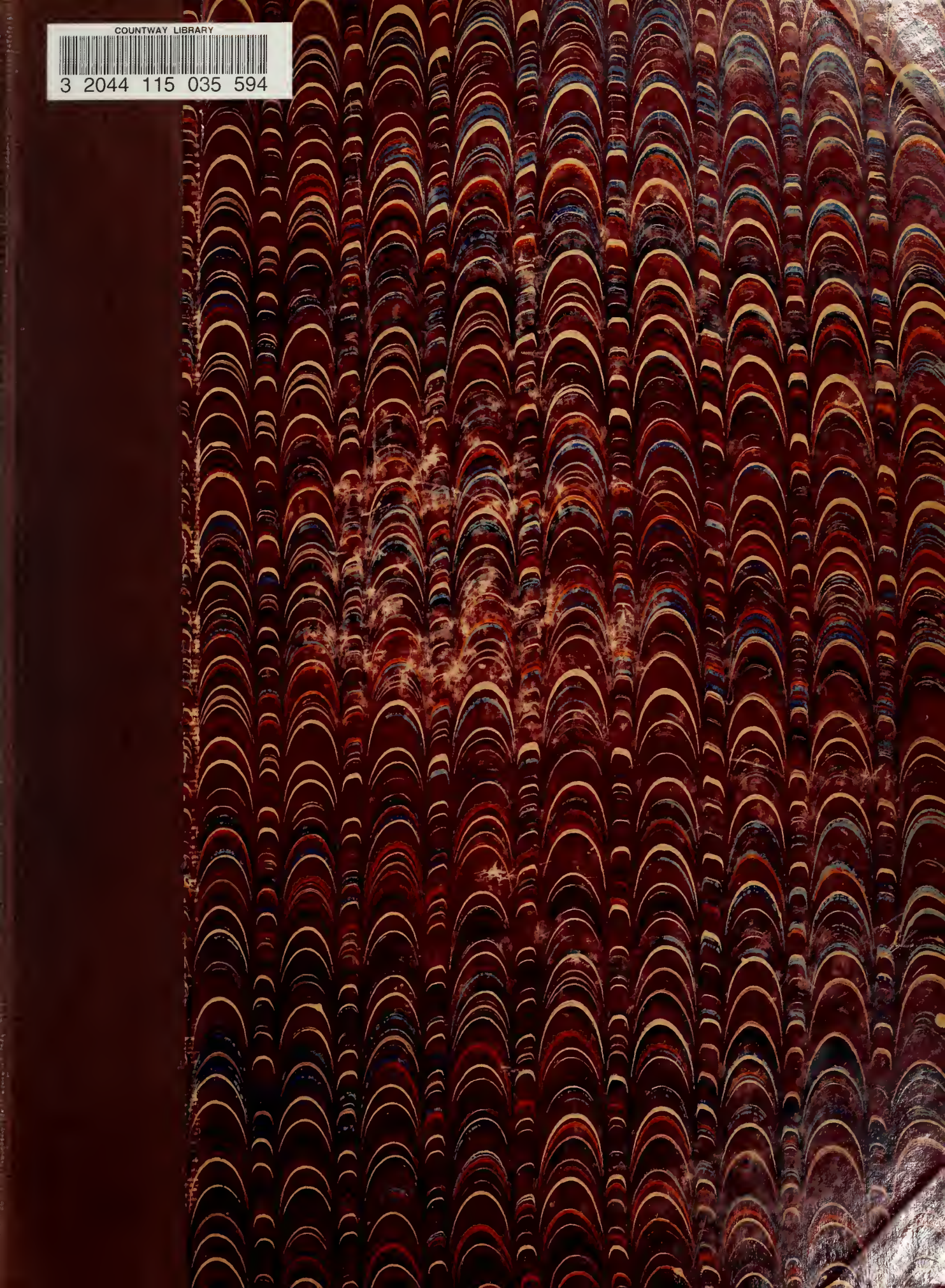
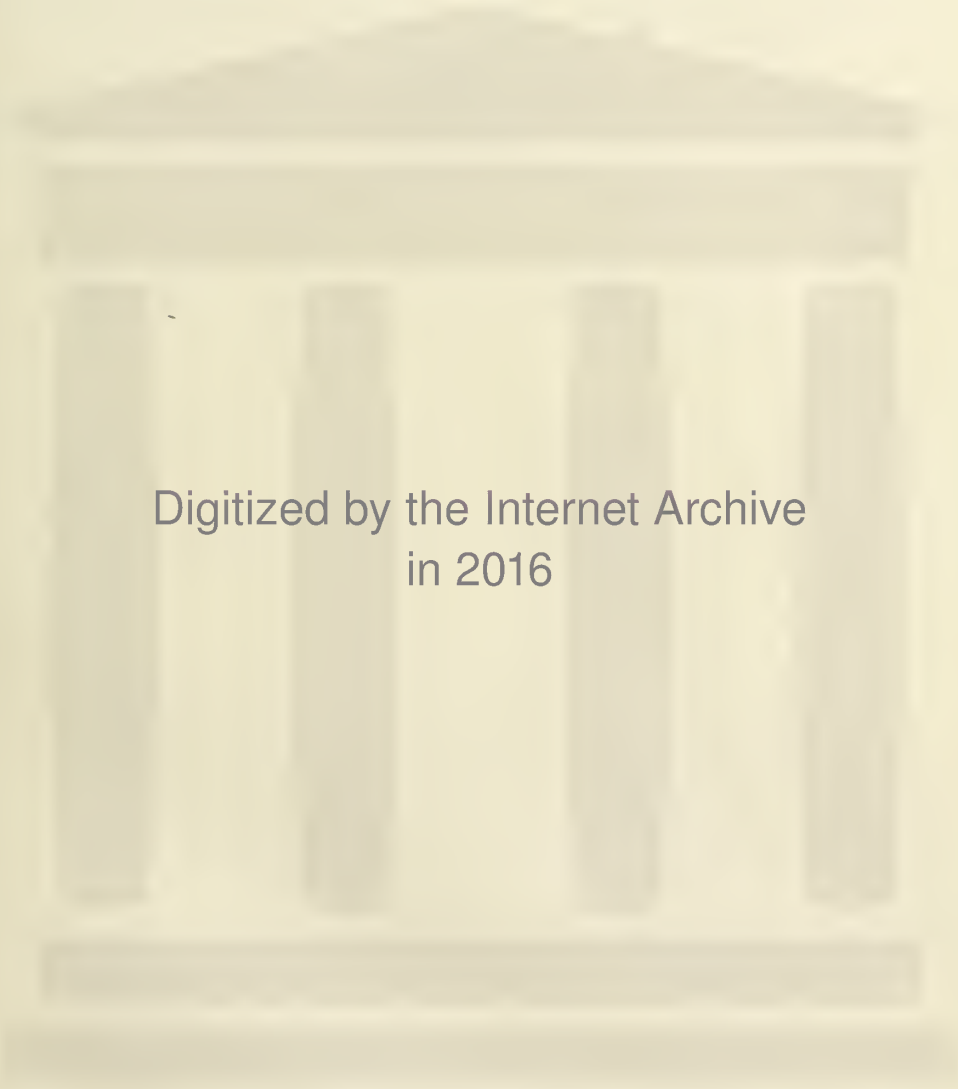
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AUG 1 1935

The OHIO STATE MEDICAL JOURNAL

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Number - - - - 1

Best Wishes for the New Year

Important News in This Issue---Including C. W. A. Medical Service and Council Action

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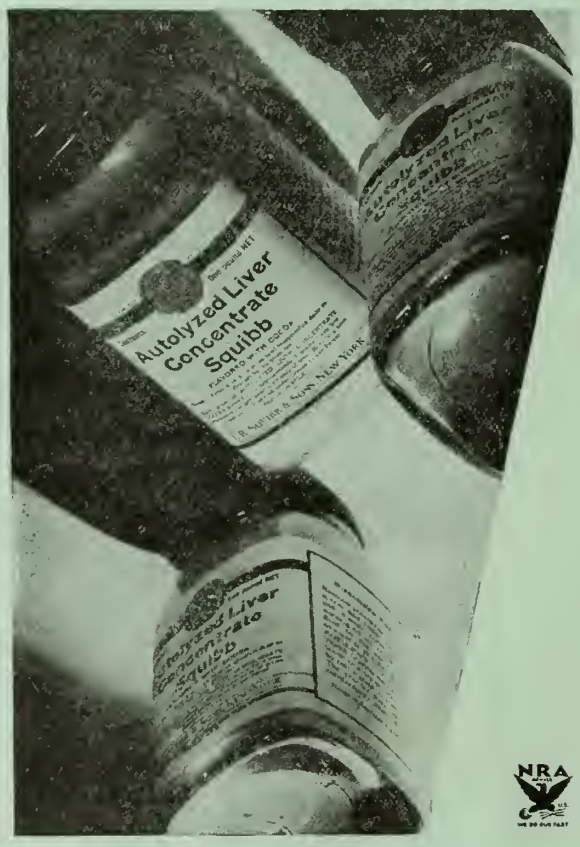
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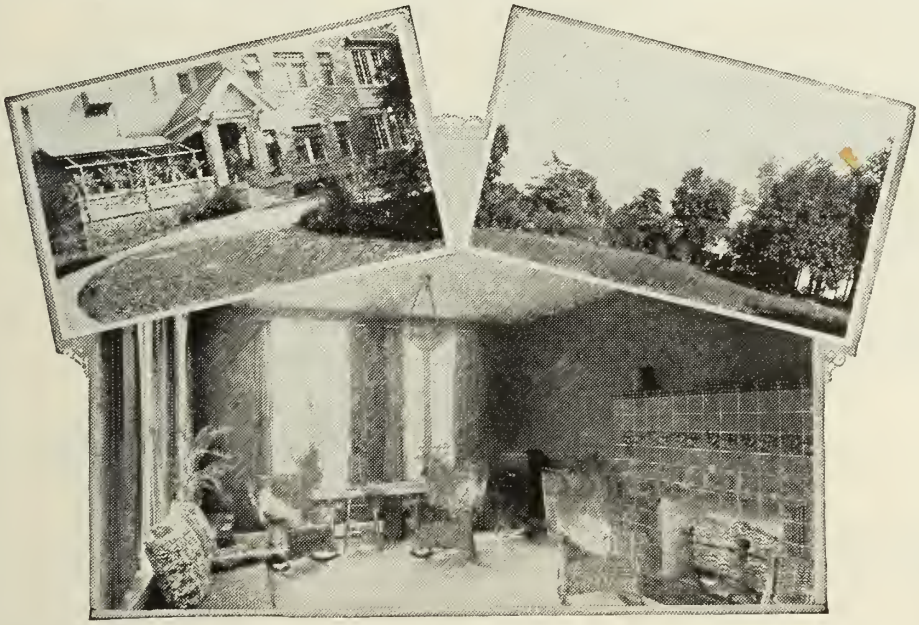
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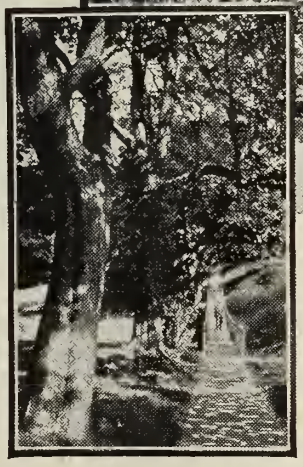
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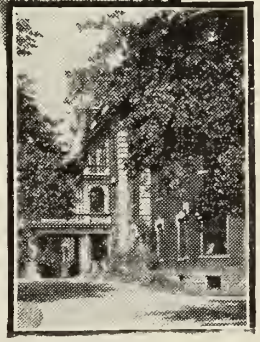
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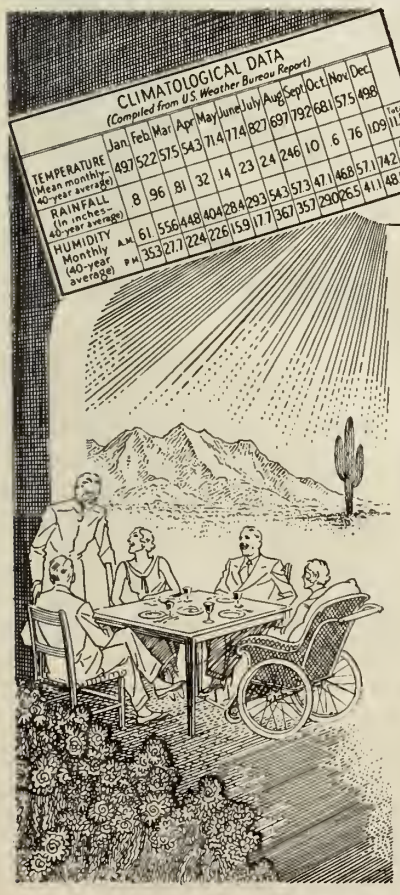
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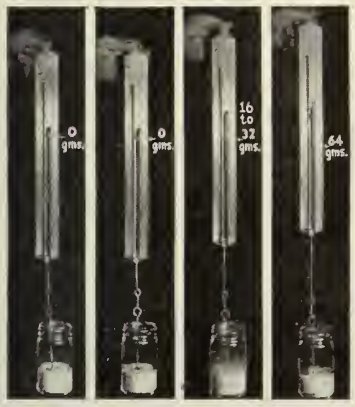
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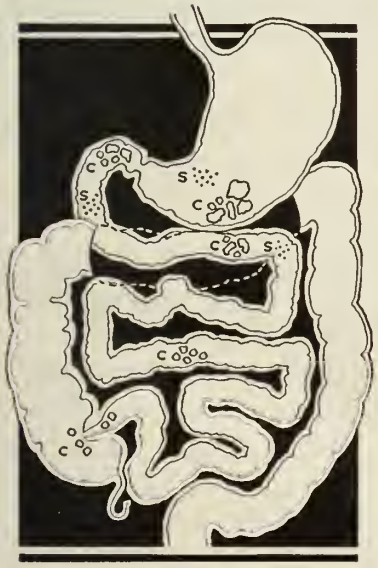
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[1] London & Polowzowa: Zeitschr. f. physiol. Chem. 1906, XLIX, 328.

[2] Marriott: Infant Nutrition, pg. 81.

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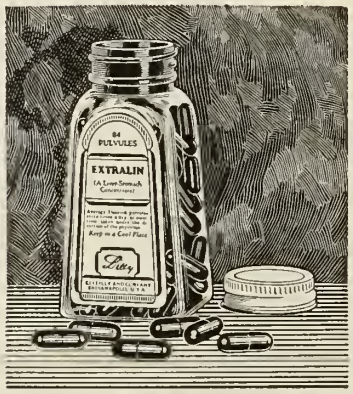
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Medical organization enters the New Year with an unusually large number of pressing and complex problems ahead.

Facing The New Year

Economic, social and governmental changes and developments—many of which are of vital importance to the medical profession and of far-reaching significance insofar as the practice of medicine is concerned—have been taking place with such rapidity that constant uncertainty has prevailed.

Unless present signs fail, the ensuing year will bring forth additional intricate questions of deep concern to physicians.

Medical organization must be prepared for a New Year of unusual activity. It must have its full strength mobilized to meet crucial situations, the outcome of which will determine the future of medical practice.

Developments of the past year have shown that important questions affecting medical practice cannot be solved by individual effort alone but many of them can be met successfully if individual efforts and initiative are coordinated and molded into organized activity.

Regardless of whether questions confronting the profession should be met on a national, state or local base of activity, the fact remains that they cannot be handled in an effective manner unless efficient organization machinery is maintained by the medical profession.

Obviously, physicians will be tremendously handicapped in meeting local problems unless they are properly organized and keep their county units at a peak of efficiency. Unless the State Association has the active support of all the eligible physicians of the state and is actively assisted in its undertakings by the component county medical societies, its effectiveness will be greatly curtailed. The attack on national problems will be exceedingly more effective if county and state organizations are active and alert.

It is fundamental that organization activities cannot be carried on in a satisfactory manner unless membership rolls are kept at their highest possible peak and the undertakings of county, state and national organizations are accorded the active support and cooperation of every member of organized medicine. At present when the medical profession is confronted with problems of unprecedented importance, it is vital that medical organization have the united support of all physicians eligible to membership. Benefits which accrue to the individual physician through membership in organized medicine will be increased if a greater number of physicians put their shoulder to the wheel and use their best efforts in seeking solutions for questions of extreme importance to all members of the profession.

Some physicians have not as yet paid their 1934 membership dues and insured themselves of continued good standing in medical organization. They should do so immediately in order that every county society and the State Association can face the New Year with their ranks united and the profession as a whole be adequately prepared to meet impending issues in such a way that the rights of the individual physician will be safeguarded and the fundamental elements of medical practice preserved.

New Headquarters Office

BY THE time this issue of *The Journal* reaches the membership, the State Headquarters Office of the State Association will in all probability have been moved into its new quarters on the 10th floor of the Hartman Theater Building, 79 East State Street (northeast corner of State and Third Streets).

Moving of the State Association Headquarters Office was authorized by the Council at its meeting Sunday, December 17. (See Council Minutes published elsewhere in this issue of *The Journal*).

Because of prevailing business conditions, the State Association was able to obtain modern and more desirable space for the Headquarters Office in one of Columbus' better office buildings at the same annual rent it has been paying.

The Hartman Building, a modern office building of fireproof construction, faces the State Capitol; is only a block and a half from the new State Office Building, and provides the State Association with quarters superior in all respects to those which have been occupied by the Headquarters Office.

At the time this issue of *The Journal* went to press, the State Headquarters staff was in the throes of packing up for the movers and it is anticipated that shortly after the New Year it will be able to hang out a "Business as Usual" sign at 79 East State Street.

Immense Taxation Problems

Unless present signs fail, one of the bitterest legislative battles in recent years will take place in the near future when the Ohio General Assembly in special session this month takes up the gigantic task of solving the present chaotic taxation situation in the state.

It has been estimated that adoption of the constitutional amendment for 10-mill tax limitation on real estate by the voters of the state in November will mean a loss of some $50,000,000 in revenue to the state and its various subdivisions.

The battle lines on the issue are rapidly being formed. Some groups of diversified interests are insisting that no new taxes will be needed but that the situation can be met by collection of delinquent taxes and by further retrenchment in the expenditures of governmental units. Other groups contend that the problem can only be met by the enactment of new revenue-producing measures, sufficient to make up the $50,000,000 deficit.

Among the sources being talked about from which to secure supplementary or new taxes are the following: Retail sales tax, gross sales tax, selective sales taxes, earned income tax, corporation income tax, increased corporation franchise tax, increased intangible taxes, increased utility taxes, license taxes of various kinds, occupational taxes.

Obviously, the medical profession should be vitally concerned in legislative trends and developments regarding the question of taxation. Physicians as a group are contributors to the funds used for carrying on the functions of government. For this reason they have a perfect right to take an active part in efforts to readjust and revamp the present taxation system. It is important that the profession understand the possibilities of imposition of discriminatory taxes and those which would put an inequitable and unjust financial burden upon the profession.

Of course, physicians, like all other citizens must appreciate the fact that in these days of serious governmental problems, expenditures are increased especially those of an emergency nature, that sources of revenue have decreased and that burdens of taxation have mounted.

The medical profession learned long ago that organized medicine must take an active interest in legislative and political affairs insofar as they affect public health and physicians as a profession and as individuals. No question is of greater importance at this time than that of taxation. At any rate, it is a question which should be given serious study by the proper committee of each county society so that the interests of the profession may be safeguarded and a course of action formulated in case prompt and forceful action should be needed.

Socialized Medicine In Canada

Judging from some of the leading medical journals of the Canadian provinces, the Canadian medical profession is confronted with the greatest crisis in its history, arising from a definite movement, backed in part by the government of some of the provinces, for the socialization of medical service on a wholesale scale.

How the Canadian medical profession has reacted to this impending revolutionary readjustment and what steps it has decided, or will decide, upon to meet the issue are of vital importance to the profession of this country inasmuch as conditions and environments in Canada and the United States are in some respects similar.

Some aspects of the Canadian situation were analyzed by the editor of the *Vancouver, B.C. Medical Association Bulletin* in a recent issue of that publication. His comments, published herewith in part, should serve as a reminder to the medical profession of this country that social and economic movements, whether they be right or wrong, recognize no geographic boundaries and that the serious problems which now confront our neighboring colleagues may easily become equally as serious issues in our own environs in the not distant future.

"The elections have come and gone, and the world is, we are assured, once more safe for democracy", the Vancouver editor opines.

"And now for King Charles' head once more. What are we, as a profession, going to do next? The present government has put health insurance in its platform, and we do not doubt that it is intending shortly to take steps to bring in as large a measure of health insurance as it can find it wise or expedient to do at this time. What is our attitude to be at this juncture, should we offer our help and constructive suggestions, or should we adopt the *laissez faire* attitude, and allow things to develop?

"We feel strongly that we should adopt the former position, and be ready with an offer of our services and experience. But amongst the other effects of the depression, is a complete realignment of the factors that go to make up the problem of medical care.

"When health insurance was first mooted, years ago, in B. C. as in other parts of this continent, social conditions were entirely different. The vast majority of people were working, and every person born into the world, at least every male person, was expected to be a working unit as soon as he reached a certain age. It had gone on so long that statistical tables were based on it as an axiom of the social order. It was supposed that our social system was stable and would remain so. Compensation funds, unemployment insurance tables, pension calculations, were all based upon a supposed security and certainty of occupation. And health insurance, as a remedy for the undoubted evils of our present system of caring for the sick, was also based on the theory of contribution by all workers to a fund. Due allowance

would be made for seasonal unemployment, but that would be all. The actuary could calculate to a dime what the cost would be, to the individual and to the State.

"But now an entirely new picture presents itself. Of course, as part of this, there is a vast increase in unemployment, but this is not necessarily permanent, though at the moment it seems to be heading in that direction. But that is not the whole of the story. The past few years have shown us that our social structure is not so stable, nor so sound as we had thought. Unemployment is not only seasonal, nor due to the laziness of the worker. It is due to other conditions of technology, of world trade and tariffs, of international relations that have not till recently been clearly seen and have not yet been grappled with, but we may be sure of one thing, that unless these problems are faced and solved in the very near future, it is going to go very hard with our civilization, and with us.

"So that the question again arises in our mind, 'Is Health Insurance an adequate solution?' or must we dig deeper? Is it not possible that we shall have to go more to the root of the matter and try to think out a scheme which will be more elastic, more comprehensive, more suited to *any* rearrangement of the elements in our social compound?

"We think so, and we think, too, that we should, in honesty and fairness, dig deeper into our own problem of the practice of medicine as a whole. We must clean house. We must remove certain of the barnacles which have grown on the good ship's keel. We cannot altogether justify or seek to perpetuate some of the present day conditions of medical practice. We know, let us be honest about it, that there are many things today which make it difficult for us to be always perfectly honest with our public."

Credits and Collections

With many of his former pay-patients on the public relief rolls and many of his remaining pay-patients in such financial straits that they are unable to meet their bills as promptly as formerly, it behooves every physician to exercise as much ingenuity as possible in his financial dealings with his clientele and to practice a bit of "collection psychology" whenever feasible.

There are a few fundamental psychological factors which every physician should take into consideration in making collections. Most of these are largely matters of tact and judgment on the part of the physician and in most cases produce surprising results if properly executed.

To summarize briefly a few of the suggestions which have been made on various occasions by those experienced in collection procedure:

1. The physician should make it clear to every patient financially able to pay something for the services received that he (the physician) expects payment for such services. The physician should discuss with the patient the question of fees and leave with the patient the impression that it is taken for granted that the bill will be settled.

2. Every patient should be tactfully reminded that his medical bill should be paid promptly. The physician who permits himself to become known as unduly lenient about his collections will be taken advantage of by some patients and in some instances lose the respect of patients who make a habit of paying their other bills on time.

3. The physician should never intimate to his clientele that collections are slow—even if they are. Make each patient believe that other patients are paying promptly and in full. Such a plan is likely to stimulate payment by those who might be inclined to neglect settlement of their account.

4. Every bill should be itemized as much as practicable. The patient presented with an unitemized statement may question the validity of the fee charged, forgetting the various small services received which make up the total amount.

5. The physician may get better results by sending out statements at a time other than the first of the month. Most persons are swamped with bills at the first of each month. Frequently more cash is available to the patient the middle of the month and there is less likelihood of the physician's bill being lost in the shuffle.

6. Credit information is important. A physician should not only know the credit standing of patients but he should have information, if possible, as to whether the patient has made a practice of meeting bills of other physicians or physicians who have treated him in the past.

The medical profession readily recognizes the value of psychology in treating the sick so every physician should realize that psychology also is an important factor in financial dealings between him and his patients.

Hospital Intern Training

In these times of uncertainty and changing social and economic conditions, it is highly important that the young man about to enter the practice of medicine be given every possible opportunity to fortify himself with as much information as possible concerning some of the problems he is destined to run up against during his professional career.

There is probably no better proving ground for the medical graduate or a better opportunity for him to learn through experience and from the counsel of experienced heads in medical practice than the hospital internship which most medical graduates enter upon completion of their academic work.

Some of the points worthy of consideration by the practicing profession and hospital administrators with regard to the internship question were discussed recently by one hospital authority, quotations from which follow:

"The psychology of the intern represents a curious mixture of student unsophistication and half matured professionalism.

"Frolicsome, schoolboyish, hypersensitive, petulant, enthusiastic, cooperative, hesitating and self-confident are terms that accurately describe

the varying moods of the intern. He has crowded his memory with facts and figures concerning human pathology and symptomatology and yet he has not learned to apply his knowledge practically. He is inclined to pity the aging physician who knows how to employ so few drugs. He has preconceived notions as to the proper conduct of hospitals, and does not hesitate to voice them. This is the type of personality which each year enters the hospitals to assist in caring for the sick.

"That the intern needs a gentle but firm hand to guide his course should be self-evident. But in many hospitals, the presentation of a book of rules and a service sheet, all but represents this most important and undertsanding tutelage. No careful instructions as to his newly acquired responsibilities—no sympathetic mentor to guide him through his first few days—no one to demonstrate that major operation, for him at least, of taking a blood specimen for a chemical study—no one but the intern who preceded him on the service from whom to receive advice as to his new work. Staff members are inclined to be hurried and exacting—to be unable or unwilling to teach—and nurses irritate in endeavoring to impart information. Little wonder that the first few weeks of an intern's hospital life are filled with many misunderstandings.

"The hospital, therefore, is often to blame when unsatisfactory service is rendered by the intern. An absence of understanding of the psychology and the practical fundamental abilities of the recent graduate in medicine, a lack of system in instructing him during his first few weeks in the hospital and an absence of evident respect for his professional standing are strong enough influences to ruin the many other possibilities that he possesses for future usefulness to the sick. The coming of the new intern is an event fraught with promise, or with possibilities for lost opportunities for service to the sick."

Important Federal Legislation

Ohio physicians undoubtedly have been reading with interest dispatches from Washington regarding the preliminary hearings being held on the much-discussed piece of legislation commonly known as the Tugwell or Copeland food, drug and cosmetic bill which would repeal the Food and Drugs Act of 1906 and set up an entirely new statute to regulate the drug, food and cosmetic industries.

An unusual amount of publicity and propaganda has been disseminated by groups opposing enactment of the measure. Charges have been made that it would establish an autocratic dictatorship in the Department of Agriculture, that the industries affected would be denied the right of appeal to the courts, that these industries would be ruined if forced to comply with the provisions of the proposed law, that it would deny the right of self-medication, and that it would impose numerous "unreasonable" and "bureaucratic" restrictions on the businesses engaged in drug, food and cosmetic production and distribution.

In some instances, opponents of the proposal have even gone so far as to accuse the organized medical profession as having written and sponsored the measure in a spirit of "selfish interest" to prevent by legislation self-medication and to destroy the patent medicine industry. This allegation is, of course, unwarranted.

The medical profession is, as it should be, vitally interested in any legislation or movement which has as its objective the furnishing of greater protection to the health and well-being of the public at large. Since the use of foods, drugs and cosmetics is vitally associated with the health of the population, the medical profession naturally is interested in and realizes the necessity for proper and reasonable laws regulating such industries and establishing a control over the production and sales of these products in such a way that the public will be protected against exploitation and the consumption of those products which are injurious to the public health. It is readily admitted that the present Food and Drugs Act has proved ineffective in many respects and should be strengthened considerably to meet abuses that have arisen since its enactment.

It may be that the so-called Tugwell or Copeland bill in its present form does not provide a perfect solution of the chaotic and dangerous situation which now exists in the manufacture and marketing of foods, drugs and cosmetics. Perhaps some provisions of the proposed law are too drastic or unreasonable. Doubtless some modifications of its phraseology and some of its regulations are necessary. To be sure, valid objections to the bill as its now stands should be heeded and proper amendments drafted.

The medical profession can with unanimity endorse the principles behind this legislation and give its approval of the motivating objectives of the sponsors of the proposal.

The medical profession believes that the American public has a right to the greatest protection that the law can offer in relationship to its health. For that reason, the medical profession is interested in the developments on this particular piece of legislation.

Physicians will be entirely justified in using their influence to aid in the passage of any legislation ultimately evolved from the Tugwell measure which in their opinion offers additional health safeguards to the public generally and which is not unfair to the conscientious and reputable groups in the food, drugs and cosmetic industries. The need for such legislation is important for the protection of the public and the protection of the rights of reputable members of the industries affected by it.

SCIATIC PAIN . . . ITS CLINICAL SIGNIFICANCE

By ALBERT H. FREIBERG, M.D., F.A.C.S.,
CINCINNATI, OHIO

THE conception of "sciatica", as it has been called for generations, comprehends a painful condition along the course of the sciatic nerve. In this country it has, chiefly but not altogether by the laity, frequently been spoken of as "sciatic rheumatism". This is sometimes the case even when the pain involves the lumbar, gluteal and anterior crural region and when it fails altogether to follow the course of the sciatic trunk or its divisions below the knee. This is evidently a fallacious nomenclature. Even when the pain is not felt in the anterior part of the thigh, however, we may find ground for objecting to the term "sciatica". In the majority of instances the pain is not felt along the course of the sciatic trunk, which is most often intact only to the middle of the thigh. Rather do we most frequently have our patients describe a pain along the postero lateral part of the thigh, continuing downwards along the course of the common peroneal nerve to the lateral aspect of the ankle and of the dorsum of the foot. It is unusual to find complaint of pain along the course of the tibial nerve which separates most often at the mid-thigh from the sciatic trunk.

Commonly enough the division of the sciatic trunk into the common peroneal and tibial branches takes place shortly after the exit from the pelvis and not rarely the division is so high that we may not speak of a sciatic trunk at all. Almost without exception these two parts of the sciatic trunk are distinctly recognizable and separate from the lumbosacral plexus down. It is questionable, therefore, to speak of a sciatica when we lack evidence that the sciatic nerve trunk, as a whole, is involved.

It has been recognized by neurologists for long that this symptom of sciatic pain is peculiar since it has not been possible, either clinically or pathologically, to identify it as the result of an *organic* nerve lesion. Excepted from this statement are those cases in which sciatic pain may be recognized as the symptom of tumor or other organic disease of the spinal cord; as the symptom of organic lesion of the nerve radicles at their emergence from the spinal canal; as the result of pressure upon the sciatic trunk or one of its main branches by tumors or inflammatory processes, either within or without the pelvis. These excepted cases are, however, in the very great minority.

Most of the cases of so-called sciatic pain, whether acute, subacute, or chronic, show no change in the reflexes of the extremity nor symptoms of interference with the transmission of nerve impulses, either afferent or efferent. There is no paralysis or paresis of motion, nor is there any disturbance of sensation, superficial or deep. Surely, upon such signs do we depend for the recognition of peripheral or radicular nerve disease elsewhere in the body. Moreover, the repeated inspection and even microscopic examination of the nerve itself has failed to determine the existence of any organic change except a congestive hyperaemia of the nerve sheath. The condition under discussion has often been denominated a "perineuritis"; not, forsooth, because a true organic perineuritis has been demonstrated but rather because the region of the sciatic trunk in the thigh is often, even though by no means always, tender to pressure and because this is a satisfying explanation.

Sciatic pain is not only troublesome to its possessor. It is too often a "bête noir" to the doctor. Often most excruciating in severity in the acute and subacute forms, the pain in many of these finally abates either as the result of appropriate treatment or in its absence—in some cases only to recur, in certain others not to be heard from again. The treatment of a goodly number of these cases in the hands of the general practitioner has been exceedingly unsatisfactory. This paper is offered in the belief that it is possible to change this situation—and that by rationalizing both the symptomatology and the treatment.

We have been told that sciatica or sciatic pain is a symptom and not a disease. I have myself said so to this Society, nearly twenty-five years ago. Very well, a symptom—but a symptom of what? To theorize at length on this subject, to discuss the finer details of anatomy is not my purpose. To make myself understood, however, I shall find it necessary to discuss briefly certain anatomical details—because I believe that in knowing them lies the possibility of explaining certain clinical facts which have been recognized for quite a long time.

While sciatic pain has been the subject of much writing for many years, most of these contributions concerned themselves with treatment; either by medication, surgical operations such as nerve stretching, or physiotherapy. Marked divergence of views and literary repetition testify to their inconclusiveness. Lasègue described the sign which has since gone by his name and which was spoken of by Goldthwait and Osgood, in 1905, as "straight leg raising". In many cases of sciatic

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pain, I should say in much the greatest number, if the knee is fully extended and the hip then flexed, one sooner or later comes to a definite limitation of this hip flexion. Whereas on the normal side this limitation is reached only when flexion to 100°, 90°, or even less, is reached, the sciatica patient resists involuntarily much before this.

In acute or severely painful cases the limitation may become manifest with only 10° or 15° of hip flexion; in others, much more motion is permitted. What I wish to emphasize at this point, however, is that a certain number of cases of sciatic pain are seen in which this sign is absent entirely. To me, this constitutes a differential sign of great importance.

Goldthwait and Osgood reported that in many cases which were Laségue positive, pain was produced in the region of the sacroiliac joint and this constituted in their opinion, and that of many others, a significant reference to this joint as the origin of the sciatic pain. It is only fair at this point to say that much variation in flexibility is found in otherwise normal persons who cannot permit 90° of straight leg raising and that some persons complain of discomfort in the hamstring tendons at the back of the knee, when this test is made, without its having any special significance. The explanation of the Lasègue sign accepted for years was that it was produced by stretching the sciatic nerve. Aside from the fact that anatomical study shows that the sciatic nerve is not put upon the stretch until the extreme of hip flexion is reached and that most sciatica patients reach the limit long before this, it has been shown (Wiedkopf Klin. Woch. 6:1927—p. 739) that anesthetization of the sciatic trunk by novocaine has no effect upon the Lasègue sign, whereas epidural or sacral anesthesia causes its disappearance. This would appear to dispose of the sciatic trunk as the seat of origin for this sign and point to something above the level of the lower border of the gluteus maximus, where the anesthetization of the sciatic trunk was made. On the other hand, while the trunk of the sciatic is tender below this point in many cases which are Lasègue positive, in many others it is not so. However, in most cases which are Lasègue positive, I feel almost like saying all of them, there is definite tenderness in the buttock; a tenderness which has been ascribed to the nerve at the "sciatic notch". While I believe this ascription to be erroneous I consider this a sign of importance.

The association of the Lasègue sign with sciatic pain, or better, with pain which seems attributable to the common peroneal branch of the sciatic, has been of great interest to me for years. About fifteen years ago I became impressed with the close anatomical connection between the sciatic but especially the common peroneal and the piriformis muscle. Recently, anatomical studies in collaboration with Dr. T. H. Vinke, have appeared to justify certain generalizations which I recount in brief:

1. The piriformis muscle is the only muscle which bridges the sacroiliac joint.

2. The piriformis muscle is in extremely close relationship with the common peroneal nerve. In 10 per cent of cadavers the nerve is found to pass through its substance. Between the piriformis and the sciatic trunk there is a rich vascular plexus coming from the inferior gluteal vessels; pressure here would call forth a passive hyperemia of the sheath of the sciatic trunk.

3. Experiment upon cadavers shows that by the Lasègue maneuvre the piriformis is put upon the stretch when only a few degrees of straight leg raising have been made—through the medium of the biceps femoris and its connection with the great sciatic ligament from which the piriformis muscle derives a part of its origin, uniformly. Part of the piriformis, moreover, is quite constantly derived from the capsular ligament of the sacroiliac joint. The piriformis may therefore be expected to react by spasm as the result of disease in this joint just as is the case with the muscles of the hip or any other joint.

Lantern slides were shown, illustrating the following points:

A.—Shows part of the fascial origin of the piriformis muscle from the capsule of the sacroiliac joint and the anterior sacroiliac ligament. Irritation of the sacroiliac joint may, therefore, be expected to result in spasm of the piriformis, since this is the only muscle which bridges this joint. An inflammatory lesion of the piriformis muscle itself will have the same effect, even in the absence of disease of the sacroiliac joint. Such involvement doubtless occurs often as a part of myofascitis of the lumbar and gluteal region, commonly spoken of as lumbago. This condition is often confused with sacroiliac disease. (Modified from Toldt.)

B.—Shows the relationship of the long head of the biceps to the great sacrosciatic (sacrotuberous) ligament and of this to the fascial origin of the piriformis. When the biceps is put upon the stretch, as in the straight leg raising or Lasègue test, the piriformis is also made taut. If the piriformis is in a state of irritation, limitation of hip flexion will appear sooner than normal. This signifies a positive Lasègue sign. (Modified from Toldt.)

C.—Shows the relation of the piriformis to the sciatic trunk, when there is no high division. Part of the piriformis is cut away showing the venous plexus between the piriformis and the nerve in front of it. In the cadaver we have found this plexus to be much more abundant.—(From Bardeleben-Haeckel-Frohse; Atlas d. Topogr. Anat.)

4. While such reaction of the piriformis upon the common peroneal or sciatic may proceed from disease of the sacroiliac joint and therefore produce the characteristic pain which we are discussing, it must also be granted that lesions, especially inflammatory processes, resident in the muscle itself may have the same effect. This would explain the pain along the common peroneal so often observed in connection with acute myalgia

or myositis of the lumbar and gluteal muscle groups and which has elsewhere been described as "myofascitis" (Albee). In this case also, we should expect to find the Lasègue test positive, in the absence of sacroiliac disease.

5. It has not yet been found possible to bring proof of purely experimental character, for obvious reasons, upon anatomical grounds. However, it seems justifiable to assume that the Lasègue sign depends upon tension made upon the piriformis muscle in the presence of abnormal conditions connected with it.

It has for long been known that cases of sciatic or common peroneal pain are of diverse nature and cause. It follows, therefore, that these must be carefully differentiated clinically in order to rationalize our therapy and to bring it to a satisfactory efficiency. For clinical purposes, I believe that we may separate these cases into two groups, remembering always that they are not invariably distinct.

Group A

The Lasègue test is negative. Here we shall expect to look elsewhere than the sacroiliac joint for the active lesion. If there are signs of impaired function of the nerve, such as altered or abnormal reflexes, paraesthesias or changes in deep or superficial sensation or of motor power, we must consider the possibility of organic impairment in the nervous system, such as tumor or other disease of the spinal cord, radicular lesions of the nerves proceeding from the lumbar intervertebral foramina resulting from arthritis in this situation (Putti and others). Especially if the sciatic pain is bilateral must we bear in mind spinal tumor. In this group also there belong those cases in which the sciatic or lumbosacral cord is pressed upon by neoplasms or other swellings, either within or without the pelvic cavity. Neither may we here forget the possibility of definitely toxic neuritides such as may occur in connection with plumbism.

Group B

The Lasègue test is positive. In this group, I feel that we must regard the piriformis muscle as involved:

1. The sciatic pain may be acute or subacute in character and associated with pain, tenderness and rigidity possibly in the lumbar muscles, but surely those of the buttock. The area of the piriformis muscle especially is tender from its emergence from the great sacrosciatic foramen to a point near to its insertion into the great trochanter. In some of these cases there is elevation of temperature, general malaise and digestive disturbance; in others this is not so, but for the present we must regard them all as fibrositis or myofascitis of toxic or infectious origin. The line of the sacroiliac joint, where it is palpable is not tender, unless simultaneously involved. This may, of course, happen.

2. The area of the piriformis muscle in the buttock is tender but not necessarily so. The onset of the pain may be sudden or not. The Lasègue test may bring forth not only limitation of motion but pain referred by the patient to the region of the sacroiliac joint (Goldthwait and Osgood). The line of the sacroiliac joint is likely to be tender to pressure, especially in its lower third. In the prone position, with one hand steadying the pelvis so as to eliminate motion of the lumbar spine, hyperextension of the hip joint by lifting the thigh, produces pain in the sacroiliac region (Yeoman). While cases are frequently encountered in which the clinical delineation is as definite as just described, it must not be assumed that this is always so. By no means. Complicated cases are seen not infrequently in which arthritis of the lumbar spinal segment, of the lumbosacral joint are seen in combination with each other or with arthritis of the sacroiliac joint. Such combinations make for difficulty in diagnosis frequently calling for experienced and trained judgment of very high order.

It is now quite in order to speak of the role of the *X*-ray in the diagnosis. I am in the habit of uttering an apparent paradox in connection with the *X*-ray in bone and joint disease: "The *X*-ray can not make the diagnosis, nor can the diagnosis be made without it." Nowhere more than here is it true that everything depends upon interpretation but particularly upon correlating the *X*-ray findings with the history and clinical status. Not only are stereoscopic views of the sacroiliac joint desirable because of its great depth, its obliquity in the antero-posterior view with resulting superposition of images, but two other facts must be borne in mind, here as elsewhere. Positive changes in the joint may be seen which represent arthritic changes no longer active; they may even have taken place without producing subjective symptoms. Anatomical studies have shown that this occurs especially often as the result of degenerative or hypertrophic arthritis, but with notable frequency in the sacroiliac joints. On the other hand, here as elsewhere, active arthritis of the atrophic variety may be in existence without showing definite *X*-ray manifestations at the time.

I take it that there will be no disagreement with the statement that exact diagnosis is the first step toward a rationalized plan of treatment and I realize that I have drawn the picture of a situation which may resemble the Gordian Knot in the difficulty of its solution. At the same time, whereas certain writers have been at pains to attribute sciatica in a broad manner to the sacroiliac joints, to the lumbosacral joints, to arthritis of the joints of the lumbar segment, it must be realized that it may be due to all of these, either singly or in combination. More than this, it is held that it may be explained as the consequence of a purely

muscular affection; fibrositis or myofascitis, if you choose to call it so. But it must manifestly be wrong to treat all of these cases in the same manner, especially so if we refer to the local measures to be employed.

In recapitulation it may be said that the Lasègue sign has never been given its proper diagnostic significance. It is my opinion that when negative, we may assume that the sacroiliac joint is not the seat of the cause for sciatic pain and that in this same case we may eliminate muscular disease, by the same token. According to the exhaustive analysis by Grossmann and Keschner (Arch. Neurol. & Psych. 21:1929. p. 398 et seq.) of 317 cases of sciatic pain, the Lasègue sign was positive in 116, therefore about one-third. While I feel that this proportion is too small, the statement is significant and it demands an explanation which has, hitherto, not been forthcoming.

It is obviously not possible to attempt the detailed discussion of the treatment of sciatic pain, in its many and diverse implications which have been set forth, at this time. It has rather been the purpose to indicate how proper diagnosis may assist us in making our therapeutic attack well directed from the beginning; in avoiding the pharmaceutic empiricism of the past, so much of which signified merely the use of one kind, or other, of analgesic and which did nothing to influence the definitive result, even though providing a temporary measure of comfort for which we still call upon them.

A good many years ago, I had the following experience: My patient, a young attorney, had been suffering from quite severe sciatic pain for a number of weeks. I had concluded that it depended upon a lesion of the sacroiliac joint and had proposed a plan of treatment which included the use of a mechanical pelvic support. About an hour after leaving me he called me on the phone and told me that a friend had begged him to try a form of treatment which his grandmother had used upon him with success. It consisted of taking a large dose of castor oil daily for ten days. He asked whether I objected to his postponing my treatment in order that he might try the castor oil. I gave my assent providing that I should be informed of the result. In four days he notified me that he was entirely well but that he intended completing the course. He remained well. My record showed that he was Lasègue positive, that the sacroiliac joint was not tender, that the attack had begun with stiff back and pain in the lumbar and gluteal muscles. I subsequently used this treatment successfully in a number of cases which I considered similar but in a number more without result. I later learned from an orthopaedic colleague that he considered senna tea, taken for a number of nights, as a remedy of great value in sciatic pain. Today this means to me that cases so relieved belonged to the group of fibrositis or myofascitis; that they depended upon toxic conditions proceeding from the intestinal tract, and that in properly selected instances the treatment may be used with success. However, there should be added proper dietary directions, suitable applications of local heat and instruction as to general hygienic measures. There is, of course, no reason to believe that either castor oil or senna have any specific virtues apart from their evacuative effect upon the intestine, nor is there reason for setting ten or any other number of days as the required period of treatment.

Much the greater number of cases which, as orthopaedic surgeons, we are called upon to see depend upon a basis quite different from the ones just described. They are, for the most part, cases of longer continuance and in which simpler measures such as just described have already been employed without satisfaction. Careful and complete study is required, in order to place them in their proper categories. Some of them, such as the spinal and pelvic tumors will have to go into the hands of surgeons properly equipped to care for them. In a large number and, I think, certainly more than one third, the diagnostic analysis will show that they are to be attributed to lesions of the sacroiliac joint, the sacrolumbar joints, the joints of the lumbar segment, or a combination of them. I shall have to content myself with certain generalizations regarding their treatment.

While nearly all of this group turn out to be arthritic in their nature, great care must always be taken in their study. I cannot help mentioning a diagnostic error of my own which passed through the hands of two excellent radiologists as well as mine. While somewhat atypical, especially in failure of therapeutic response, the case proved later to be one of incipient sarcoma of the iliac bone. There was little consolation for me in the thought that correct initial diagnosis would not have influenced the lethal termination. Should we have to conclude that we are dealing with arthritis in one or more of these joints, the problem of arthritis in all of its implications is before us for attack. I can not now dwell further upon this.

Most often, in addition to those measures which are calculated to influence arthritis by recognizing its relationship to infection, to metabolic or endocrine disturbances and by applying ourselves to the regulation of diet, to immunological methods and medicines, we are called upon to help by means of procedures more mechanical in their nature. Relief of pain is the first demand. When this is severe and especially to the degree of interfering with sleep, complete recumbency will be required for a period. However, recumbency in an ordinary sagging bed will give these patients but little comfort. They require more in the control of motion, more support to the lumbar curve to counteract the drag upon ligaments. These are best provided by making the bed rigid by means of boards under the mattress and by means of

placing a "loin pillow" under the lumbar hollow. This pillow should be firmly stuffed with curled hair, not more than one and one-half inches thick, five inches wide and fourteen inches long. To this is most often added weight and pulley traction to the affected extremity, applied in about fifteen degrees of flexion and the same amount of abduction of the hip joint. The Russell, or so-called "Australian" method of traction has been found particularly comfortable and efficacious and five to six pounds of weight usually enough. This method is maintained until relief from pain is complete. Before being permitted to be up and about, the patient is fitted with a support which controls motion of the pelvic joints, of the lower spine, or both, according to the diagnosis and our consequent decision concerning the individual need. There should follow suitable physiotherapy by means of diathermy, infra red rays, massage and later exercises calculated to restore muscle control.

In certain instances, whether by reason of the severe degree of local disease or the nature of the patient's employment, we fail to obtain relief for our patient. Or, having secured relief, we are by the nature of these conditions unable to maintain it contingent upon reasonable conditions of life activity. Under these circumstances resort must be had to surgical operations looking toward the bony fusion of the joints which are involved. I shall not now discuss these operations farther than to say that, properly chosen and efficiently done, they have been shown to be of utmost value and have had, perforce, to be given a perfectly definite place as a means of help. They have certainly furnished the means of restoring permanent comfort to many, of returning them again to gainful activity, of providing grateful appreciation for both of these accomplishments. Properly approached and managed with judgment and skill, the vast majority of cases of sciatic pain need no longer be considered a bug-bear or bête-noir of medicine.

I have not pretended to cover the whole differential diagnosis of all of the conditions which may produce sciatic pain. This would carry me too far. My main purpose has been to direct attention to the clinical significance of sciatic pain as this must be modified by a knowledge of the role which is played by the piriformis muscle, its relation to the sacroiliac joint and the light which is thus thrown upon the meaning of the Lasègue sign. Moreover, I am persuaded that as we learn more of the real meaning attaching to the symptoms and signs to be found in our patients, we shall be able to depart from the conception that there is in the sciatic nerve a condition to be spoken of as a "neuralgia" and which has no discoverable organic condition as its basis. Whether this be intrinsic or extrinsic to the nerve, I believe that such organic condition always exists and that it requires recognition before treatment can be rationalized. Perhaps this is true of all the neuralgias and not simply of the so-called sciaticas.

707 RACE STREET.

THE STATUS . . . OF PEPTIC ULCER IN 1933

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THE status of peptic ulcer in 1933 bears a striking resemblance to the economic situation of the world today. The brain trust in the government and in medicine have failed to discover the etiology of either condition. Treatment is by trial and error. Finally, the analogy is complete in that recovery is uncertain.

The excuse for this presentation is the voluminous and confusing literature which has appeared during the last few years. Recently, Redwitz and Full in a monograph of 387 pages have epitomized the enormous literature on the subject.

An attempt at correlation will be made. For the purpose of this paper the discussion will be limited to acute and chronic ulcers appearing in the lower esophagus, stomach, duodenum and jejunum (the latter occurring after gastroenterostomy.

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HISTORY

First reference to round ulcer was made by Galen. Cruvielhier in 1829 gave the earliest comprehensive description of peptic ulcer as we know it today. Then came Rokitansky, Virchow and Quincke who gave the name "peptic ulcer", still the designation of choice.

More recently Moynihan contributed much to progress especially by his insistence upon the value of a careful history of the patient.

ETIOLOGY

Research in peptic ulcer has been devoted extensively to the stomach itself in spite of the many indications that constitutional factors have a predisposing relationship.

There exists a fair percentage of agreement that the highly strung vagotonic individual is most prone to ulcer. This nerve imbalance has a tendency to follow family lines. To my mind, the disturbance of the sympathetic nervous system is a fundamental element in the production of ulcer.

Carl Rokitansky in 1841 described a type of ulcer in the newborn accompanied by intracranial lesions. He said: "The proximate cause may be looked for in diseased innervation of the stomach, owing to a morbid condition of the vagus, and to extreme acidification of the gastric juice."

Harvey Cushing[1] refers to experimental production of ulcers in animals with the comment that "It is only in man that ulcers occur spontaneously with any considerable frequency and it is not at all improbable that this prevalence has something to do with the stress and strain of modern life."

The psychic aspect as a causative factor has been emphasized only recently. The autonomic nervous system has no doubt some definite relationship to ulcer.

Cushing operated upon three patients with intra-cranial tumors who died from perforation of acute ulcer. This contribution from a brain surgeon has revived interest in the neurogenic element in ulcer causation. A very lucid account of such a theory is given by Dr. Ralph C. Brown[2]:

"The parasympathetic apparatus, in all probability, under normal conditions is affected by cortical or psychic influences. However this may be, direct stimulation of the lobes or of their descenting fiber-tracts or a release of the vagus from paralysis of the antagonistic sympathetic fibers, leads to hypersecretion, hypermotility, hyperchlorhydria and hypertonicity, especially in the pyloric segment. By the spasmodic contraction of the musculature, possibly supplemented by accompanying local spasms of the terminal blood vessels, small areas of ischemia or hemorrhagic infarction are produced, leaving the overlying mucosa exposed to the digestive effects of its own hyperacid juices."

Virchow's announcement from the study of the pathology of ulcers at necropsy is the second most important theory. A host of investigators has corroborated his conclusion that every ulcer base has one or more arterial lesions. Recent work as illustrated by that of Schutz[3] indicates that an infarct is present in 100 per cent of peptic ulcers. Why the arterial occlusion? Another unanswered problem.

The bacterial theory in the production of ulcer is very intriguing. Rosenow[4] in 1913 propounded a theory that "streptococci quite irrespective of their original source, when of a certain grade of virulence, exhibit affinity for the gastric mucous membrane, producing a localized infection and ulcer". He admits that some factors not present in animals tend to produce chronicity in man.

G. Hauser[5] states that Rosenow's work proves "that bacteria or toxins excreted through the mucous membrane can produce necrosis and ulcers in the stomach which in most cases are anatomically different from typical simple ulcers".

For a hundred years bathing of the stomach with hyperacid gastric juice has been given as a cause of ulcer. In my opinion, this role in etiology is only an aggravation after the fundamental causes have paved the way for the disease. How else explain the few cases reported by reliable men in which hydrochloric acid is not present? Doubtless retention, spasm of the vessels and musculature have a more important bearing than hydrochloric acid itself.

Next in order of importance let us consider experimental ulcers. A recent resume by Mann and Bellman[6] of Rochester is comprehensive. Typical chronic peptic ulcers have been produced by methods which involve the action of strongly acid chyme upon the ulcer area. The process of development in man has not been determined.

These research workers state "if the mucosal lesion in man which precedes the development of the characteristic chronic peptic ulcer begins as a hemorrhage into the submucosa, it would appear that many of the results of our investigations would have little, if any, clinical bearing. On the other hand, if the lesion in man begins at the surface of the mucosa, the type of lesion we have studied would appear to be the only type of experimentally produced ulcer that may be of clinical significance."

No one cause will, in my opinion, be found for ulcer. The final analysis will doubtless place the "hypersthenic gastric diathesis" of Hurst and Virchow's circulatory disturbance producing an hemorrhagic or an ischemic infarct as most important.

Thirty-three years ago Dr. Max Einhorn gave a clinical course in diseases of the stomach to a class of six physicians. We were given very careful instruction in gastric analysis and the taking of a history.

Even then the question of abnormal fermentation and stasis were stressed. After careful titrations for hydrochloric acid and total acidity tests for lactic acid and occult blood were made, then we were able to diagnose ulcer, cancer, or achylia gastrica. We were very well satisfied with our diagnostic ability. Later, however, the introduction of the fluoroscope and frequent operations for ulcer, cancer and gallbladder proved the problem was much more intricate.

A prominent Columbus surgeon assured me a number of years ago that he would not accept a diagnosis of peptic ulcer from any internist. The experience of frequent laparotomies performed upon such a diagnosis with no ulcer demonstrable had forced this conclusion. At the time I resented his attitude, but I am now convinced he had ample justification for such an opinion.

When we realize that rather extensive ulcers are seen at necropsy in people who had suffered no symptoms of indigestion during life, the difficulty of a correct diagnosis is evident to us.

Surgeons of experience as well as internists who follow their cases to the operating table see evidences of error in judgment. Mistakes are made

with the abdomen open and under actual observation. A skillful Columbus surgeon explored the abdomen of my patient for a diagnosed gastric ulcer. Careful scrutiny showed no evidence of disease in the gallbladder, stomach or duodenum. The abdomen was closed. A cerebral hemorrhage afforded an opportunity for necropsy which was made forty-eight hours after operation. An extensive linear ulcer was found on the posterior wall of the lesser curvature.

This and similar cases suggest the advisability of opening the duodenum or stomach when palpation at operation fails to reveal an ulcer.

Peptic ulcer is the most difficult abdominal diagnosis. The anamnesis should not be referred to a nurse, secretary, or inexperienced medical assistane. A proper history is all important and should be taken by the physician himself. I do not agree with those who say the history alone is enough to decide upon duodenal ulcer as a diagnosis.

Gastric analyses for the chemical findings, occult blood, etc., are valuable as is also the tubing of the fasting stomach. Fluoroscopy and *X*-ray plates are useful. Abdominal shadows with hyperperistalsis should be checked after atropine.

There is no pathognomonic test of duodenal ulcer by *X*-ray. The same irregularity in the cap may be seen from adhesions following cholecystitis without gall stone colic. This conclusion has been reached to my sorrow at operation.

Careful and intelligent roentgen studies offer the most valuable means at hand for diagnosis. One must not forget in this connection the possibility of low esophageal ulcer.

Pain, its time of occurrence and character is a very important consideration. When the distress is severe enough to require an opiate for its relief, pyloric obstruction or more frequently, cholelithiasis, must be considered. Night pain with food relief is rarely found except in duodenal ulcer. Finger point tenderness over the pylorus is a most valuable aid in diagnosis. Still more helpful is the localization of this spot by palpation under the fluoroscope following barium.

The benzidine test for blood in the stomach contents will very often be positive, when no lesion of the alimentary tract is present. This may result from even a slight traumatism on intubation or from the gums. Hence, positive blood in the chyme should be taken cum salis grano. Repeated positive tests for blood in the stool are more significant.

In every case Kahn tests should be made. Many patients have symptoms and history closely simulating ulcer but with positive Wassermann or Kahn. These people are cured or improved by antiluetic treatment without rest or diet.

In the words of Dr. Anthony Bassler[7] "an ulcer either exists or it does not, and there should be no twilight diagnosis lit with questions and shadowed with doubt."

TREATMENT

There are three prerequisites to any method for a cure of peptic ulcer:

(1) A relief from the worry, irritation, and nervous imbalance of the patient.

(2) The use of bland, non-irritating and frequently administered food.

(3) The patient, not the ulcer, must be treated.

Treatment instituted after an early diagnosis is the most satisfactory. This may be accomplished by a constant suspicion that the patient with a supposed functional neurosis, hyperchlorhydria, or indigestion may have peptic ulcer.

Clarence F. G. Brown[8] and others say that "the majority of peptic ulcers heal with no treatment or any treatment."

The above statement with the admitted fact that no etiology has been agreed upon, emphasizes the chaotic condition of therapeusis.

No less than thirty dietary procedures have been suggested. The most recent one was reviewed in the *Journal of the American Medical Association* of September 2, 1933. The method proposed is the use of a continuous drip of milk and alkali through a duodenal tube. This plan has been carried out in forty-two patients over a period of twenty-two months. The favorable results may scarcely be evaluated after such a limited time. One object of treatment is an effort at peristaltic rest. How can a permanent tube aid in this effect? The large percentage of ulcer patients are neurotic. How many of your patients would be willing to subject themselves to this procedure?

Mann and Bollman[6] remark that at present there is no one best method of treating peptic ulcer, either medically or surgically. Merely to enumerate the dietetic, diathermic, intravenous, intro-muscular and surgical methods of treatment would require many times the space allotted to this contribution.

Formerly, hospital and bed treatment of peptic ulcer was considered essential to a cure. Recently, however, ambulatory management with diet and some form of medication has frequently been found to arrest the symptoms. Bismuth was a favorite drug in that it was supposed to coat the ulcer. Later, relief was often found after use of barium for *X*-ray diagnosis. My patients have been free from symptoms while taking barium sulphate. This fact has been applied successfully as a therapeutic measure.

Having diagnosed peptic ulcer what should be done?

Never advise surgery until medical means have proved futile over a long period of time. The ambulatory method is preferable at the start with six weeks of a bland, largely milk diet. Add to this bismuth, barium, or mucin before meals.

During an experience of thirty-three years in the medical treatment of peptic ulcer, I have found no remedy as reliable as gastric mucin. Several otherwise intractable cases have been relieved of all symptoms, have gained weight and a perfect condition of euphoria by its use. Some patients suffer recurrences when this product is discontinued. However, even if it prove to resemble insulin in this respect, we have found a most valuable remedy.

The earlier preparations of mucin contained histamine and were not very palatable. Recently, however, Ivy and Fogelson have induced at least one manufacturer to produce a purer extract. It is not nauseating and does not stimulate the formation of acid.

Clarence F. G. Brown and others[8] report the results of mucin treatment on 116 patients; thirty-seven of these were intractable over a long regime by other systems of management. The summary of their article contains the following pregnant statements:

"Mucin does not lower gastric acidity appreciably—for four to seven hours. From our objective observations the therapeutic effect is due to some factor other than neutralization of acid."

Ultimate evaluation in any treatment must be withheld for at least five years after its introduction. This is naturally true of mucin therapy.

Ambulatory management of ulcers is not always successful with alkalies, belladonna, mucin, foreign protein injections or a host of other cures. If after eight weeks no improvement has been experienced, hospitalization should be advocated. Rest in bed with the use of a bed pan for two weeks is essential for the best results.

The treatment should be preceded by a dose of oleum ricini. During the first seventy-two hours rectal feeding should be used with nothing by mouth. It is surprising how many patients are free from pain if their minds are at rest and confidence in recovery is established. Following this, daily enemas (no physics) are given and daily hourly feedings of milk and cream are used.

Three weeks of such management with heat to the epigastrium will often work wonders. This is the time honored Leube-Rosenthal plan of management. Part of it psychic? Yes, perhaps so.

The Sippy alkaline and dietetic method was tried by me in ten hospitalized cases soon after its introduction. These patients had less pleasing results than occurred with my usual Leube-Rosenthal regime. No permanent success has been experienced by me in the use of alkalies. Hyperacidity is best controlled by a change in the patient's mental attitude, physical rest, and proper diet. Drugs such as belladonna, or when pain is severe, codeine, are helpful. In some manner other than neutralization of the chyme, bismuth, barium, or gastric mucin seem to relieve the ulcer pain.

Finally, in treatment success depends upon treating the patient—not the ulcer. Psychotherapeutic measures are just as important as any other of the many physical methods to be chosen. A general plan of treatment should be adopted by each physician and in this procedure he must have faith.

SURGERY

The controversy between surgeons and internists about treatment of peptic ulcer has largely exhausted itself. Most surgeons of a conservative mind are quite willing to have the medical man struggle along with uncomplicated cases.

Dr. F. H. Lakey represents a high type of conservative surgeon. He says[9], "Any impartial attitude toward the modern management of gastric and duodenal ulcer at once admits the important fact that peptic ulcers are today no longer primarily surgical. A patient with gastric and duodenal ulcer cannot, with propriety, be passed on to the surgeon for immediate operation as can the patient with gall stones, appendicitis, hernia, and removable tumors. He must come to surgery as the result of the failure of medical management or because of the demonstration of certain surgical indications."

Many internists believe that when operative interference is undertaken a resection of the ulcer bearing area should be performed. The surgeon's alibi in refusing to do this is that the mortality is too high. Those of us who feel that simple gastroenterostomy is a poor procedure answer that the technique of radical gastric surgery should be so improved that death will occur in a smaller percentage of cases.

CLOSING REMARKS

For the benefit of those who were not present when my paper was read let me say that my experience with the use of alkalies in the treatment of peptic ulcer has been very disappointing. Such substances as bismuth, barium and especially gastric mucin relieved the pain in ulcer without neutralizing the stomach contents. Some one in the audience asked me why I was so enthusiastic about powdered gastric mucin before the five year period of trial had been reached? My answer is that such a high percentage of people have been relieved that it seems to be the medicament of choice.

Question: What has been your experience in the use of foreign protein? My only observation has been in the treatment of patients who have been cured by this method.

Question: What manufacturer's product of mucin do you use? The name of the manufacturer was purposely omitted from the paper but if the president thinks an answer should be given I use the product of the Frederick B. Stearns & Co.

In the treatment of any disease when the cause is not known we are apt to be creatures of habit. I think that most of the profession has the alkaline habit. In my experience the use of a

proper diet with either bismuth, barium or mucin and mental and physical rest will accomplish more cures or the arrest of symptoms than any other method.

The most distressing case in my experience was in a young man who had a typical history of duodenal ulcer covering a period of two years. The laboratory and *X*-ray findings coincided with the history. He was given barium in the evening, examined the following morning and returned the next day for his report. He refused treatment because all his symptoms disappeared with the first dose of barium. There has been no return of disturbance for eighteen months.

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THE EYE . . . IN RELATION TO MODERN INDUSTRY

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THE eye is the only organ in the body which has suffered in the changes of modern industry. Previous to the era of mass production most eyes were lost by gun fire, discharges from blasts and a few from flying foreign bodies in machine shops but the advent of high speed tool steel which will retain its temper while at white heat and with rapid turning lathes the number of foreign bodies which penetrate the globe are enormously increased. Unfortunately, many of these metallic materials are non-magnetic and it is difficult to remove them from the eye without doing much more damage than if they were highly magnetic. While a state campaign a few years ago showed the dangers of cheap hammers and battered punches and chisels the improvement which was gained in the number of these accidents has been offset by the vastly increased number of accidents to machine tool hands. Then too, the abrasive wheels, emery, carborundum, etc., etc., together with the polishing materials have increased the number of minute foreign bodies embedded in the cornea. The use of all these has greatly increased in later years.

All the increase in blindness in the last 25 years in industry has been by mechanical accidents. The only exception to this is the use of electric welding which has now become a much used technique in industry and unless the operators' eyes are carefully shielded, and many of the masks are insufficient, they then will develop a burn of the lids and blindspot in the retina. It has not been realized that bystanders, especially those who work in close proximity when this work is going on, can suffer almost as much as the operator. The electrical discharge of blasting charges has lessened the danger materially from this source. With the old fashioned lighting fuse and black powder a certain number of them refused to burn or burn so slowly that when investigated they frequently went off and ruined the eye of the employe.

None of the occupational diseases of industry affect the eyes to any extent. Poor lighting is responsible for some eye strain but the mechanical lathe which holds its own tool and finishes the job before stopping has relieved machinists of much eye strain. Two factors in present day industry to save the eye should be:

1. A better grade of goggles which will belong individually to the man using them. These should be ventilated and it should be his duty to keep them clean.

Two railroads in the United States have at their own expense bought goggles for their men who were subjected to eye dangers of industry and both of them report that there is a satisfying decrease in the number of blind eyes during the year. The cost of prevention has been absorbed by fewer injuries. When goggles are left at the wheel to be used by anyone they are apt to be greasy, badly fitting and in fact, seldom used. The second factor is:

2. The attitude of industrial commissions toward those taking care of diseases of the eye. The Ohio Industrial Commission will not pay the general practitioner at the same rate as the specialist for treating an eye, but they have not yet forbidden the general practitioner to do eye work in cities and towns where specialists are available. Eventually, industrial commissions and self insurers under the compensation laws will find a marked lessening in expense and better treatment by limiting the eyes to a proper qualified specialist.

A great many of these cases which would be returned to work in a few days without loss of vision if properly treated, are so unintelligently handled that there is a small loss of vision, up to total economic loss, for what should be only a few

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days' disability. The workman who gets a foreign body in the eye in the outskirts of the city may be told by his foreman to go to some doctor who lives near there and it is not treated as intelligently or scientifically as by a specialist in this line of work. Whether it would be right for the Commission to refuse permission is a matter that is open for discussion but cases that are treated by competent specialists suffer much less disability than those treated by the physician who may live immediately adjacent to these shops.

In mass production where much of the material is produced by automatic machinery there will always be the danger of flying particles from one machine hitting a nearby operator who may be as far as thirty feet from the machine from which the foreign body comes. It would seem there could be an alignment or set up of machines in irregular intervals that would lessen this danger and it may be in the form of plate glass which should be interposed between these machines or around them to prevent these accidents. On the railroads there have been fewer disabling accidents since the engine men and firemen are both apt to wear goggles. In repair work the hacksaw has superseded the cold cut and sledge and has lessened accidents in this direction.

The factory hospital of industrial plants is a factor that must be looked into before factory accidents can be reduced to a minimum. The first treatment that is given an imbedded foreign body often determines what the disability will eventually be and in the smaller concerns employing, say, fifty hands or less, these cases are not as apt to be properly treated as one of the larger shops. It is interesting to note how few eyes have ever been injured by broken glass from the spectacle lens. This is often thought of as a very positive danger but in actual practice it amounts to practically nothing.

One rule which I think should always be made is that any man grinding a tool on an abrasive wheel unless the wheel is amply protected by plate glass guards should himself wear goggles. Another suggestion to which I think there should be no exception is that any man who has lost the vision of an eye should wear a glass on the remaining eye for protection from foreign bodies even though no correction be needed in the glass itself. After forty years glasses for age are needed to enable the employe to do good work. I have had a few cases where the second eye was lost in the same manner as the first and the loss of both eyes could have been easily avoided by the simplest kind of glass, as the particles are so small they do not break the lenses.

The safety first program in schools should include instructions not to use files and very highly tempered steel for punches when they are not intended for that purpose and also against the use of cheap cast iron hammers which are often bought for a few cents and thought to be good enough for household use. In industry, hammers should be supplied of lead or copper and battered punches ground off or replaced.

Refraction for tool makers, die sinkers and machinists should include a regular examination and proper supervision and this would increase the ability to do proper work. A trained employe has a money value to his employer and should not be subject to the ordinary turnover of labor. The present financial depression has proved that a group could be given special care at a lower price if not subject to loss in collection. This type of men are intelligent enough to appreciate the value of their eyes, the most necessary tool in their occupation. Too often the care of employes' accidents is turned over to very acute getters of business although not the highest class of physicians. The best of care would not cost more than this mediocre attention if the employer himself is interested in choosing the service. With proper protection from accidental injury, and care when such accidents occur, with advice as to the prevention of diseases which cause a loss of economic vision, including examination for glasses, the total loss of vision from modern mechanical industry, including the inevitable accidents, age and disease, could be reduced to the minimum.

The only disease which has made progress in the last fifty years has been "trachoma" or granulated lids. Some years ago I read an article before the Ohio State Medical Association on the importance of the spread of trachoma in Ohio. A few careful observers in the larger cities acknowledged that this was their experience that it had been spreading but the great concensus of opinion from the smaller and non-manufacturing centers was that they had not noticed it. While this is a fact and the law is that they are to be reported to the health office, nothing is done about it, no segregation and no treatment, but the time is coming when there will be such a drag and expense that dollars will have to be spent where cents would do it now. We only have to study the experience of Prussia and other foreign countries where it had gained a foothold before the dangers were recognized.

CONCLUSIONS

To obtain the best results for the employe and the employer and the most economical administration of any agency of compensation, the following suggestions are made:

1. Every employe should be examined before engagement and tests made to determine:

a. Whether there is any disease present which should be treated.

b. Whether there is any condition which will be made worse by the employment sought.

c. Whether by fitting of glasses the efficiency of the employe can be increased.

d. Efforts made that every employe be working

under the most favorable circumstances possible considering his welfare first.

2. The employer whether insured in the regular compensation act or a self insurer should see:

a. That the injured men are referred to competent men to treat them and not to someone who is simply friendly toward the boss or immediate supervisor of the employe.

This latter is very important as poor care means increased expense by the State and taxpayer for compensation, lessened production for the employer, and increased disability to the employe which no money can pay for.

b. The employer should consider it a proper charge in the cost of his product to supply men with shatter proof glasses in the shape of goggles and proper service to maintain their eyes at the highest efficiency.

After forty years of service in this line I feel confident that very much better service can be given to the employe and the State by a carefully considered plan by which only men whose competency is proved would care for these cases. The employe has a duty, however, to report any change in his vision from time to time and these tests if properly supervised can be made for a few cents per man. He must also be willing to wear protective goggles, which he is not willing to do now, but he has a right to expect them to be personal and not used by the entire force. Certainly we are not doing the best we can from an economic point of view, and a truly economic point of view is a correct point of view scientifically.

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MORTALITY RATES OF OBSTETRICAL DEPARTMENTS IN GENERAL HOSPITALS

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THE purpose of the writer in presenting this paper is to review some statistics already offered, to add to these, additional facts obtained later, and to make some suggestions for improvement of existing conditions. Most of the data presented were gathered by the Cleveland Hospital Obstetric Society. The suggestions offered are largely the result of discussions brought out at our meetings.

This society was organized in March, 1932, to study hospital delivery mortalities, their causes and prevention. We found that the first step necessary to this study was to define what is meant by delivery or obstetric mortality.

Sociologists and health department statisticians have quite generally based their figures on the so-called puerperal death rate of hospitals. By this method the number of live births in the hospital for one year was ascertained and the total number of puerperal deaths. The percentage of puerperal deaths to live births was then estimated and called the puerperal death rate of the hospital. This is not in any sense the puerperal death rate. In order to estimate the puerperal death rate of an obstetric hospital one must know the number of pregnant women treated in the institution over a given period. This would include all the live births, all the still births, all the ectopic pregnancies operated, all the miscarriages and abortions treated, all the toxemias cared for, etc. One might then find all the puerperal deaths and estimate the puerperal death rate of the hospital. It is evident that such figures would be useless for any purpose, except that of sociological studies.

In order to study the efficiency of the hospital, one must know the death rate among women who come to the hospital and are delivered there of a fetus of viable age. This is the delivery or obstetric death rate of the institution. This criterion is equally accurate for any type of hospital. Even knowledge of the obstetric death rate does not give a complete picture of the quality of work done unless one also takes into consideration the type of cases coming to that hospital. In many large cities some one institution, such as the city or county hospital, is a dumping ground for all the infected and desperate cases which no one else wants to accept. Even the highest type of work can not give good statistical results under these circumstances.

How many septic abortions are brought to the hospital and die is of scientific interest. How many ectopic pregnancies are operated and how many of these die, is also of importance. But neither of these matters is related to the efficiency of the institution as a place for women to have their babies. Yet exactly such figures have been used to show that general hospitals are unsafe for women in child birth.

According to health office figures in Cleveland in 1931, there were seventy puerperal deaths in general hospitals. The ratio of puerperal deaths to living births was 11.1 per thousand. Of these seventy maternal deaths, in thirty-four the fetus was not of viable age. These were caused by sep-

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tic abortions, ectopic pregnancies, early toxemias, etc. Some of them occurred in hospitals with no obstetric departments. But all go to make up the ratio of puerperal deaths to live births in general hospitals. The true obstetric death rate was 5.5 per thousand instead of 11.1. If we omit City Hospital with its unusual type of clinical material, from the list, we find that the general hospitals had an obstetric mortality of 4.5 per thousand, and the maternities 4.7. Allowing for errors in estimating viability, etc., the delivery or obstetric death rate of the two types of institution was the same.

An analysis made by our Society showed that for the years 1930, 1931 and 1932, two maternities had 10304 deliveries but only two deaths from abortions. During the same period, four general hospitals with 9176 deliveries had seventeen abortion deaths. City Hospital had twenty-four fatalities from this cause, during this period. The explanation is simple. Maternities properly refuse septic abortion cases, while the general hospitals just as properly accept them.

The relatively high number of puerperal deaths from sepsis in the general hospitals is obviously due to these same septic abortion cases. We made a study of the deaths due to septic infection after delivery of a fetus of viable age. According to this study the maternities with 10304 deliveries had eighteen obstetric septic deaths, while four general hospitals with 9176 deliveries had thirteen. The ratio is slightly in favor of the general hospitals, but here again the element of possible error is sufficient to warrant only the assertion that among the hospitals studied, delivery or obstetric deaths, from sepsis, occur with equal frequency in the maternities and in the general hospitals. The figures show no difference in efficiency depending upon type. All the evidence favors the view that the obstetric staff, the hospital administration, and the type of cases accepted, determine the obstetric death rate.

Whether in the hospital, lives are lost that might have been saved, can only be ascertained by careful study of the individual circumstances surrounding each case. We found that in our group of hospitals, 77 per cent of the patients dying in the hospital, were admitted with known pathological conditions on entrance. During the three year period fifteen of the patients dying in the hospital were delivered at home and were later brought to the hospital and died there.

Of the sixty-eight cases which we classified as septic hospital obstetric deaths, thirty-one were obviously infected before admission to the hospital.

Among our own group of hospitals we obtain detailed case reports of each fatality. Errors of technique or of judgment are brought to light and discussed. Every physician and hospital representative belonging to the group, knows that fatal cases will come up for impartial review. This puts every man and each hospital on its toes lest poor technique, untrained judgment, unnecessary intervention, or neglect shall be thought responsible for a fatal termination.

Mere defense of obstetrics as done in general hospitals is far from our purpose. Constructive criticism is necessary if progress is to be made. There is no controverting the fact that infected cases of all sorts are brought to, and housed in, general hospitals. There is no denying that this state of affairs makes necessary, complete segregation of the obstetric patient.

It is a fact not sufficiently recognized, that conditions and surroundings found safe for general surgery are not adequate for the protection of obstetric patients. Aseptic precautions in general surgery are based upon intensive protection of a small area (the field of incision) for a short period of time. After the incision is closed it is covered with occlusive dressings, and protected from further risk of infection. No such limited intensive protection is possible in obstetrics. During labor which lasts from six to twenty-four hours or longer, the patient is stirring about; the perineum is contaminated by bowel movements; pads must be changed as they become soiled, etc. Sterile cap, gown and gloves for the attendants during all this time are impracticable. After delivery is completed, occlusion of the field by dressings is still impossible. The tissues of the generative tract are bruised and lacerated, and this tract leads directly to the wide open sinuses of the placental site. The atria for infection remain wide open, until nature has had time to close them by building up a protective wall of granulations. Therefore the space devoted to housing these patients, the attendants, the linen, the apparatus used, must be free from the slightest suspicion of recent contact with infection of any sort.

The following recommendations are concurred in by our hospital group.

STAFF ORGANIZATION

"Every general hospital accepting maternity cases should have obstetric recognition in its staff organization. In the larger institutions, there should be a regularly organized department, with a trained obstetric specialist, responsible for and directing the work of the division. In small hospitals, even in the small community hospital, it is possible to have a qualified man in the capacity of consultant in obstetrics. The advice of this man should be always available, concerning matters of policy or technique.

THE OBSTETRIC UNIT

"Physical segregation of an obstetric unit, combined with administrative isolation of this unit, are conditions which should be fulfilled by any general hospital accepting maternity cases.

PHYSICAL SEGREGATION

"Delivery rooms, scrub rooms, nursery, and rooms for mothers, should occupy one continuous unit of space, not interrupted by space used for any other purpose. This unit should be so situated that attendants and visitors to other portions of the hospital, do not pass through the obstetric unit. Delivery and scrub room should not be located in one part of the hospital, while nursery and rooms for mothers are located elsewhere. This arrangement offers opportunities for contamination. The obstetric unit should be a real physical unit, and is prerequisite to administrative isolation.

ISOLATION OF THE UNIT

"This can be secured only when the administration heartily co-operates with the staff to make it effective. Nurses and maids caring for obstetric cases should not have contacts with patients of any other type. The linen used for obstetrics should be used exclusively for this purpose. The laundry should not be relied upon to destroy virulent pathogenic organisms with which linen may chance to be infected by a draining surgical case. Bed pans, douche bags, thermometers, irrigating apparatus, and all other paraphernalia, used in the obstetric ward, should remain there and should not by any chance be borrowed for temporary use elsewhere!!"

Such obvious and dangerous mistakes as building the delivery room into the surgical operative space; scattering obstetric patients throughout the hospital; using the same utensils for both surgical and obstetric cases; permitting the same nurses and maids to serve both types of patients, etc., would rarely occur if the administrator consulted freely with an obstetrician, or if such a man were in charge of the obstetric division.

A most important factor in reducing the incidence of sepsis is prompt removal of infected cases from the obstetric unit. The general hospital is most advantageously situated in this respect. The case that is frankly infected when brought to the hospital, should not be taken to the obstetric unit for delivery. Any case which develops questionable symptoms after delivery, should be transferred to some other portion of the hospital. The baby should always accompany the mother when she is moved to another section. Not only does the general hospital have at command, readily available space for this purpose, but it has what is of even greater importance, a personnel continuously maintained, which has no contacts with the obstetric division. Prompt and complete isolation of a suspicious case is more difficult in a maternity than in a general hospital.

RESUME

1. Large general hospitals and special maternities are equally safe for obstetrics, provided they are equally well directed by a competent staff and a good administrator.

2. Proper staff organization; physical segregation of the obstetric unit; and administrative isolation of this unit, are the necessary conditions for a clean obstetric department in a general hospital.

3. Better standards for hospital obstetrics are encouraged and fostered by such group hospital studies as we have instituted in Cleveland.

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ENCEPHALITIS LETHARGICA

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ENCEPHALITIS Lethargica (epidemic encephalitis or influenzal encephalitis) or erroneously termed "sleeping sickness," is an infectious disease of the brain, characterized by nonsuppurative inflammation, functional and organic alteration of the tissue cells from bacterial toxins, and usually involving the gray matter. No attempt is made here to discuss the other types of encephalitis except possibly the casual mention of the form known as Encephalitis B, which assumed an epidemic status in the St. Louis district.

Since the pandemic of influenza in 1918, encephalitis lethargica in its chronic form has become rather prevalent. While not all such cases develop psychotic manifestations there are some who do. These maladjust to society, and develop an inability to properly care for themselves and are eventually sent to a state hospital. Any mental symptoms, however, are secondary and minor to the existing physical disability. These physical incapabilities serve as constant reminders to the afflicted patient and this fact contributes to the development of a possible psychosis, which usually assumes the form of abnormal agitation, an attitude of restlessness, mental anxiety, and sometimes delusions. In a great majority of these individuals the normal intellectual resources are retained for many years, and they may perform mental work to which they have previously been accustomed, providing the existing physical handicaps do not prevent. The severity and nature of an intervening psychosis depends greatly upon the patient's previous intellectuality and personality.

Unfortunately the limited scientific literature on this subject is not always clear and systematized, and for this reason the general medical man inexperienced in psychiatry or neurology apparently has very little knowledge concerning all phases of this not uncommon disease. Mistaken diagnoses are common, and in such cases the individuals naturally do not receive the much needed proper treatment. Even in text books this disease is often dealt with incompletely, the meager and limited information being of very little practical value from the standpoint of etiology, pathology, symptoms, and treatment. The purpose of this paper therefore is to bring together all the essential phases of encephalitis lethargica, insofar as possible, and to present an uncomplicated picture of the condition to the man in general practice, and who has not had the privilege of studying these cases in our state hospitals.

A great majority of these cases are not hospitalized, but are still attempting to carry on regardless of their neuro-physical handicaps. The course of the disease is usually a slow process after the chronic stage is reached. In fact after a certain point is reached the patient's condition may apparently become arrested. The gratifying therapeutic action of specific treatment in most cases produces much optimism on the part of the patient, and he seldom demonstrates any insight as to the possible grave prognosis as far as a cure is concerned. Most encephalitis cases of the chronic or sometimes termed post-encephalitis type have a desire for physical or mental work, and their inability to execute not infrequently causes them to lapse into a depressed, or an emotional state, or perhaps a state of mental agitation.

As aforesaid, many of these cases whether in the acute or chronic form are never diagnosed as encephalitis lethargica. Especially in the acute stage are incorrect diagnoses made. It is not uncommonly called meningitis, infantile paralysis, typhoid fever, brain fever, toxemia, etc. In the chronic stage it is not uncommonly slated as multiple sclerosis, poliomyelitis, neurasthenia, hysteria, stroke, paralysis agitans, infantile paralysis, spinal cord disease, cerebral syphilis, malingering, cerebral thrombosis, cerebral hemorrhage, etc. A careful study of neurological and clinical symptoms together with serological findings should effect a correct differential diagnosis.

Encephalitis lethargica is a disease of the brain and its neuropathology produces a physical disability which eventually renders the patient helpless. They become unable to perform their usual duties due to the existing physical inhibition, and too often, to solve the problem to those concerned, they are declared psychotic and sent to the state hospital to become wards of the state. Under proper and rigid therapy the disabilities are minimized and life is prolonged and the individual may continue to be useful to himself and others for many years. The encephalitis patient who previously depended for a livelihood upon manual labor is indeed unfortunate. The mental worker is less unfortunate, and upon proper treatment he may, regardless of his affliction, carry on his work efficiently for many years.

In view of the recent epidemic of Encephalitis B. or so-called "sleeping sickness" at St. Louis and the publicity given it by the lay press, it seems proper to incorporate here a few words of comment as a matter of comparison. Encephalitis lethargica or the form with which this paper deals, is very common and occurs sporadicly and not infrequently in every community. Unfortunately, it is often diagnosed as some other condition. It is only mildly contagious in its acute form and not at all contagious when the condition becomes chronic. Encephalitis B. or that form which invaded St. Louis seems to be markedly contagious. Since the publicity of the incident has been great, sporadic cases of "sleeping sickness" have been recently reported in Ohio and elsewhere, but it is believed that in reality these reported cases are the usual encephalitis lethargica and *not* the Encephalitis B. It seems improbable that the B type has or will become pandemic.

ETIOLOGY OF ENCEPHALITIS LETHARGICA

That this disease is associated in some manner with influenzal infection, seems to be well established. History informs us that encephalitis lethargica has followed every pandemic and epidemic of influenza since the one in France, Germany and Italy in 1718. Naturally at that time conditions were not described in modern terminology as we have it now. We well know the prevalency of encephalitis since the pandemic of influenza in 1918, and including cases following sporadic influenza since that period. Flexner has said that this disease was not well understood. However, with the cooperation of Dr. Arthur G. Hyde, superintendent of the Massillon State Hospital and during my thirteen years as assistant superintendent of that institution, we were able to do considerable research study of this malady, and much information was gained. Influenza assumes one of the following forms: (1) Respiratory, (2) Gastro-intestional, (3) Febrile, and (4) Nervous. It is more often from the respiratory and nervous form that encephalitis becomes a sequela. Influenza may have other sequelae also, such as meningitis, brain abscess, myelitis, etc.

In true influenza there is no leukocytosis. This is also true in the acute phase of true encephalitis lethargica regardless of the elevation of body temperature. The leukocytes seem not concerned with the presence of the influenza bacillus, which has been found in the spinal fluid. It would therefore seem apparent that the same organism causes both influenza and this form of encephalitis. Pfeiffer isolated the influenza bacillus in 1892. Few have doubted its etiological status, and filter-

ed bodies have been cultivated and which were claimed would produce influenza. A careful history of the encephalitis patient will most always reveal an attack of influenza or an acute attack of illness which was undoubtedly influenza but perhaps not diagnosed as such at the time.

Acute encephalitis lethargica attacks the individual when the invading organism, presumably the influenza bacillus, localizes in the brain and usually after remaining dormant in the body for many months following the influenzal infection. However, in a few cases the acute encephalitis may occur in conjunction with the influenza attack. Diagnoses at this time are not infrequently obscure. The remission which usually occurs between the influenzal infection and the development of acute encephalitis or the localization of the infection in the brain is similar to the remission which takes place in syphilis prior to the development of brain syphilis or paresis or the localization of the spirochaete in the brain, or the tertiary stage in some other organ. However, these remissions as regards influenza and encephalitis usually consist of a few months instead of a few years as is the case in syphilis.

PATHOLOGY

The most pronounced pathology in this type of encephalitis is found in the mesencephalon or midbrain which connects the pons with the hemispheres. In the acute phase there may be a congestion of the frontal lobe, the pons, and the optic thamamus, and which process may not extend to the point of cell destruction. Cell destruction is marked in the intercalatum or substantia nigra and there is found minute perivascular hemorrhages.

It is not necessary in view of the intended purpose of this paper to discuss the neuropathology in detail. It is purely an inflammatory process non-suppurative and due to bacterial toxins which result in the alteration or destruction of the brain cells. These cannot be regenerated or replaced by normal cells. Hence the importance of early and proper treatment, and which may arrest the pathological process. With proper therapy we believe that some acute cases are curable and the incurable chronic cases prevented. Early diagnosis is important and before the cell pathology has progressed beyond the toxic irritation and stimulation stage, and into the cell destructive stage. Many deaths undoubtedly occur during the acute phase. Deaths in the chronic form of encephalitis are not usually due directly to the malady. Nor is it probable that the organisms survive for any great length of time following the acute stage. Abnormal neurological findings exist as a result of altered functional powers or cell damage, and not necessarily due to any persistent presence of the bacteria. The disease in its chronic form cannot be transmitted to others, and is therefore not contagious. Causes of death during the chronic stage are due to some intermediary disease or condition, and not infrequently a metabolic or endocrine complication.

SYMPTOMS

These are objective and subjective. In the acute form of encephalitis lethargica the onset is rather sudden. Severe headache is almost a constant manifestation. Elevation of temperature. There is usually drowsiness or delirium. Coma may occur. In some cases there may be mental confusion instead of actual delirium. Diplopia is fairly constant, and there may be upward movements of the eyeballs or they may be fixed in this position. The pupils are sluggish and may be unequal. Twitching of the extremities is noted. Vomiting may or may not accur. Somnolence may be an initial or late symptom. Visionary defect is common, and there may develop lid ptosis. Apparent weakness of the extremities, hemiplegic in character. There is anorexia and pyrexia, and an unmistakable picture of toxemia, together with its pronounced effect upon the nervous system. Restlessness is rather common. There is a tendency for the head to be drawn to one side. The leukocyte count is normal or not greatly increased. The differential blood count is about normal. The blood findings confirm the non-suppurative process. Serological examinations including the spinal fluid are negative, except a possible increase of pressure. The superficial and deep reflexes are usually hyperactive but are of no importance in differential diagnosis. Death may occur, or the patient may recover from all acute symptoms after two to seven weeks. If the invading organisms have been destroyed and there has been no brain cell destruction, the individual can be considered cured. On the other hand, if the opposite condition exists, the acute phase passes into the chronic or else there may be a remission of a few months to two years until the chronic form manifests itself.

The progress of the chronic phase of encephalitis lethargica is usually slow, and as aforesaid, a point may be reached where it may remain stationary. These cases are not at all uncommon and may be seen on our streets almost daily. It is characteristic that most of them seek medical aid at frequent intervals. Upon proper treatment they become very optimistic and will cooperate and carry out any medical advice or treatment given them.

The symptoms of chronic encephalitis are somewhat diversified. A common initial complaint is a weakness of the extremities of one side, especially the leg, and later on the arm of that side. The muscles assume a state of tonicity eventually. Restlessness is fairly constant. Speech defect and retarded articulation become common symptoms. There may be or may not be some difficulty in deglutition. The patient may assume a state of extreme anxiety as regards his affliction. The so-

called Parkinsonism or Parkinson's syndrome develops, which in many particulars may simulate Parkinson's disease or paralysis agitans; however, this latter neurological condition is usually bilateral and is a disease of later life. Encephalitis lethargica may occur in children as early as the second year and in the adult as late as the fifty-fifth year, but these extremes are very exceptional.

The patient finds it difficult to execute voluntary movements, especially on the one side. Characteristic tremors and myoclonia of the affected side eventually become evident. The gait becomes peculiar and is executed with apparent precision. There is a mask-like facies. The body movements become slow but with an air of deliberation. The tonicity of certain muscle groups causes characteristic body postures. There is an absence of independent head motion. The body may be inclined somewhat forward and perhaps laterally, especially in walking or running, and he or she may appear as though a stumble or fall was likely at any minute; however this is usually a late symptom. The motor powers are sluggish. Catatonic postures are assumed when resting. Disfunction of the second, third, fourth, sixth, and seventh cranial nerves may become evident, as may be expected due to the anatomy of these structures and the existing pathology. The pupils are impaired and do not react normally in about 90 per cent of the cases. They may be unequal. In the more pronounced and later stage of the chronic form sialorrhea is common.

There is no dementia of note present regardless of the suggestive appearance and behavior. There is not usually any intelligence defect except when the malady has developed in childhood. Orientation and memory are not impaired. The mentality is clear, but the ability to express is usually inhibited. Chronic cases may exist and be up and around for 20 years or more, and with no very great change in general health or neurological symptoms, especially if taking treatment. Others may become totally incapacitated and bedridden, and endocrine or metabolic disturbances may complicate. The seriological findings are negative except there is a constant low sugar content in the spinal fluid.

In most untreated cases a psychosis eventually intervenes usually from anxiety and worry over their disability, and they may become depressed, despondent, or agitated, and often times delusional. Early ophthalmoscopic examination is interesting as a rule but by no means necessary. However, it will usually show pathology such as optic neuritis, optic atrophy, choked disk, etc. Amaurosis may occur but is exceedingly rare. A late manifestation may be a conjugate deviation of the eye balls, or the so-called Oculogyric crises. Convulsions are very rare.

PROGNOSIS

Due to the destructive pathology of brain cells there is apparently no cure for encephalitis lethargica in its chronic form. However, by proper symptomatic therapy the physical incapabilities and mental stress are markedly alleviated, and the patients are made capable of doing things and performing tasks which were previously impossible, and the pathological process may be apparently arrested. They experience more general comfort. The prognosis in the acute stage has been mentioned elsewhere. The course of the disease is prolonged over a period of years. Death usually occurs from intervening complications.

TREATMENT

In the acute stage rest in bed with quiet surroundings are of course essential. Some patients may show a marked restlessness, and a tendency to become uncontrollable from pain or delirium. In such cases morphine sulphate grains one-sixth or one-fourth by hypodermic is indicated. Or in some cases sodium amytal grains three may be given by mouth. Convulsions are exceedingly rare in both acute and chronic encephalitis, but do occasionally occur. In such cases sodium amytal is effective in checking the seizures, administered either by mouth between attacks or intravenously, the dosage never to exceed 7½ grains at any one time. The dosage in children should be in proportion and given with precaution. Morphine is ineffective and in my opinion is contraindicated in most types of convulsions.

Establishment of proper elimination is important in the acute case of encephalitis lethargica. The body should be kept warm at all times, and cold applications, preferably ice caps, to the head constantly. Give liquid nourishment, including fruit juices. Pneumococcic serum in my opinion is indicated, and apparently has given very good results. Very small doses of vaccine with antigenic proporties may be given instead of the serum. Gentian violet has been used intravenously, but with doubtful results.

In the chronic form of encephalitis of this type, the treatment is mostly symptomatic, as the brain pathology would suggest. The best results are obtained from the use of stramonium which may be given in the form of the tincture 20 to 30 minims T. I. D. to an adult, and if necessary the dosage is increased gradually and cautiously to the point of tolerance which may be when the patient is taking 50 minims or possibly more. The drug seems to be well tolerated in most cases, and if given properly will not usually produce any ill effects, except possibly some dryness of the mouth, but by this action overcoming any sialorrhea which is an annoying and repulsive symptom in some of the late cases.

Various concurrent symptoms in encephalitis may occur such as gastrointestional, visual disturbances, etc., and may not always and necessarily be due to the drug. However, it should be obvious that stramonium is an acronarcotic and

poisonous in abnormal dosages. Under stramonium treatment the Parkinson symptoms are markedly lessened, and the patient is gratefully comforted by the alleviation of these tremors. The annoying inhibition of muscle action is relieved to a great extent. The muscle tonicity is replaced by muscular relaxation of a fairly normal character. The other neurological handicaps are lessened, including difficulty of speech, the act of deglutition, etc. The patient feels better, and can do more and can accomplish physical and mental tasks which were previously impossible. He has a greater ease of mind, and any possible psychotic symptoms are minimized or abolished. I have seen patients who were unable to walk, regain that faculty; however, these of course were exceptional.

Stramonium preparations tend to deteriorate in therapeutic value to some extent, and it is believed that fresh stock is more satisfactory. In my experience the tincture made from the fresh undried leaves is very effective. Any standard USP preparation is satisfactory. I have used with very satisfactory results Lloyd's colloidum stramonium with ten minums as the average or possibly the maximum dose. Stramonium leaves are sometimes used and with equally good results as the liquid preparations. The dosage is usually two or three grains twice daily, but which may be increased slightly and gradually with increased tolerance.

In beginning the use of stramonium in any form it is advisable to use the smaller dosages, followed if necessary by a gradual increase to a point of tolerance or where therapeutic results are obtained. This drug has replaced and is superior to hyoscine hydrobromide which may be used with fairly good results in dosages of one-fiftieth grain two or three times daily. Some alternate its use with stramonium. Neither drug should be given on a full stomach if the best results are desired. In view of the possibility of the existence of any inflammatory exudate in the brain, it is believed that a rigid course of one of the iodides is sometimes indicated. Potassium iodide may be given by mouth, or the sodium iodide intravenously. Calcium gluconate as an adjuvant may at times be administered in these cases. A check-up should be made occasionally upon the endocrine and metabolic functions. Urinalysis should be made at reasonable intervals. Sexual incompetency occurs in some cases but is often obliterated after a reasonable course of stramonium. However a few cases will require special medication.

Aside from the medicinal treatment of chronic encephalitis or post-encephalitic conditions, cheerful and optimistic psychotherapy is very essential, and may assist quite materially in preventing the development of a psychosis.

510-511 OHIO MERCHANTS' BLDG.

Sixth District Meeting January 10

The 227th session of the Union Medical Association of the Sixth Councilor District will be held at McKinley Hall, Massillon State Hospital, Massillon, on Wednesday, January 10.

The session will open at 10 a. m. with a paper by Dr. Arthur O. Gilliam, Massillon State Hospital, on "Hallucinations and Diagnosis". The rest of the program for the morning session has not been definitely arranged. Luncheon will be served at noon after which a business session will be held, including election of officers.

In the afternoon, two scientific papers will be presented and an address made by Dr. C. L. Cummer, Cleveland, president of the State Association. Dr. John D. O'Brien, Canton, will discuss "Some Considerations in the Treatment of Neuro-Syphilis". Dr. Arthur G. Hyde, superintendent of the Massillon State Hospital, will present a paper on "Nine Years' Experience with Malaria in the Treatment of General Paralysis".

Officers of the district society are: Dr. A. E. Brant, Youngstown, president; Dr. J. H. Seiler, Akron, secretary, and Dr. Harry S. Davidson, Akron, councilor.

Two retiring members of the medical faculty, University of Cincinnati, were honored recently by being made professors emeritus by order of the Board of Directors of the university. They are: Dr. E. O. Smith, director of urology and director of the urological service at Cincinnati General Hospital and Dr. Victor Ray, Sr., professor of ophthalmology and director of the ophthalmological service at the Cincinnati General Hospital. Other faculty changes authorized were: Dr. Gordon F. McKim, formerly professor of clinical urology, appointed professor of surgery and head of the urological division; Dr. Clarence King, assistant professor of clinical ophthalmology, named professor of ophthalmology and head of that division; Dr. Frank M. Coppock associated professor of gynecological surgery, named professor of surgery and head of the gynecological division; Dr. Frank Lamb promoted from associate to professor of pediatrics; Dr. Laurence B. Chenoweth, professor of hygiene, permitted sabbatical leave.

Application blanks now are available for space in the Scientific Exhibit to be held during the 1934 session of the American Medical Association, June 11 to 15 at Cleveland, Thomas G. Hull, director of the Scientific Exhibit, has announced. The Committee on Scientific Exhibit requires that all applicants fill out the regular application form and requests that this be done as early as convenient. The final date for filing applications is February 26, 1934. Any person desiring to receive an application blank should address a request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

The President's Page

A Personal Communication to the Membership from

C. L. CUMMER, M.D., *President*, Cleveland, Ohio

THE year 1933 has passed into history with its record of epoch-making governmental and social changes, and before us lies 1934. What it holds for us under the New Deal we know not, but of one thing we are certain, it must be faced with courage and the willingness to adjust ourselves to rapidly changing conditions.

For practically all the component societies the change in the calendar year also means at least a partial change in its officers, and it is to the officers that this is addressed especially. Traditionally, we all start the new year with new resolutions, and the first of these should be for us the intensification of individual and collective effort. The importance of strong, well-organized local societies is becoming more apparent every day, and there can be no strength without leadership. In addition to energy and high ideals possessed by those who have been singled out by their fellows for leadership, should be added judicious and deliberative temperance. A fire-brand may be useful in some situations, but as a president he is often dangerous and may undo the good accomplished through many years of constructive efforts. To the presidents then may we say it is well to consider carefully any new policies or methods and to weigh them in the balance of practicability. Furthermore, projected policies should be considered carefully that they may harmonize with those of the State Association.

Presidents come and presidents go; the majority serving for only a year, occasionally for two years, but rarely longer. Fortunately many succeed in bringing new ideas to their societies, stimulating helpful activities, harmonizing discordant factions, raising the ideals of medical practice in their communities. But as officers and leaders their opportunity is soon over.

But with the secretaries the situation is different, for among our component sosieties secretaries of five years' experience are not rare, and there are some who have served for over twenty years. The secretary has an especially important office, for his shoulders must carry the real responsibility for the success of his society, and his capacity for detail work and his faithfulness to it will be the measure of the society's achievements. The office is of importance not only to the society itself, but because it constitutes the link with the State Association.

To the members of component societies we wish to say that it is distinctly to their interest to support their new officers to the best of their ability. If the officers fulfill their duties, they deserve your encouragement and support; they are doing difficult work for the members entirely without compensation, except in the very few cases of secretaries who receive small stipends. Encourage them by attending the meetings, especially when there is a guest speaker, for what is more embarrassing for an officer than to induce a speaker to travel many miles to speak to a corporal's guard? Remember that your officers will work all the harder in your interest if they feel that you support them wholeheartedly. You can help your county secretary especially by paying your dues promptly so that he may remit to the headquarters office the per capita dues for this Association, thereby lightening his labors and at the same time keeping yourself in good standing as a member. *Remember that these dues should be paid now to keep you in good standing for the new year now starting. Many of the important rights and privileges of membership including medical defense and subscription to our Journal, are prejudiced by delinquency in dues, so for the sake of yourself and your hard-working secretary pay your dues at once.*

COUNCIL SETS NEXT ANNUAL MEETING DATES AND ACTS ON PROBLEMS OF POLICY AND FINANCE

MINUTES

The Council of the Ohio State Medical Association met in the headquarters office, Columbus, at 1:00 P. M. on Sunday, December 17, 1933.

Officers, Councilors and committeemen present were: President Dr. Cummer, President-Elect, Dr. Caldwell; Ex-President, Dr. Platter; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Paryzek, Davidson, Shanley, Brush, and Seiler; Dr. Stone, chairman, and Dr. Alcorn, member of the Policy Committee; Dr. Southard, State Director of Health; Dr. Bigelow, chairman of the special committee on *X*-ray problems in hospital contracts in workmen's compensation cases; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

In the absence of Dr. Goodman, the secretary of Council, President Cummer designated Dr. Brush as acting secretary for this session of the Council.

The minutes of the Council meeting held on October 29, 1933 (pages 776 to 779, inclusive, of the December, 1933, issue of *The Journal*), were read, and on *motion* by Dr. Seiler, seconded by Dr. Huston and *carried*, were *approved*.

1934 ANNUAL MEETING DETAILS AND DATES

Dr. Paryzek, the chairman of the Council Program Committee, reported in detail on recommendations for alternative arrangements and schedules for the 1934 annual meeting for the consideration of the Council.

On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the Council decided that the 1934 annual meeting should be a two-and-one-half days' session.

On *motion* by Dr. Davidson, seconded by Dr. Seiler and *carried*, the dates of Thursday, Friday and Saturday, October 4, 5, and 6, 1934, were set for the next annual meeting to be held in Columbus.

The extent and time of the meeting having been determined Dr. Paryzek suggested the following tentative schedule:

FIRST DAY

9:00 A. M. Opening General Session and House of Delegates.

10:30 A. M. General scientific sessions, including medical clinics.

12:00 Noon. Luncheons for college, class and fraternity reunions.

2:15 P. M. The six scientific section meetings, each to present four or five papers of twenty minutes each.

8:00 P. M. General Session—annual addresses of the retiring and incoming presidents, entertainment and an address by a popular speaker.

SECOND DAY

8:30 A. M. General Session, including clinics by one or more prominent speakers from outside the State.

10:30, 10:50 and 11:20 A. M. Scientific addresses on subjects of general interest.

12:00 Noon. Organization Luncheon for officers and committee chairmen of component county societies, section officers, committees, officers and Council of State Association.

2:00 P. M. Symposium by speakers from the faculty, Medical College, Ohio State University.

3:30 P. M. Second and last session of the House of Delegates.

6:30 P. M. Dinner or banquet, if local committees desire to schedule such a function. Otherwise, General Session either scientific or on subjects of public interest, especially affecting the medical profession.

THIRD DAY

9:30 A. M. General Session—surgical clinic in charge of out-of-state speaker.

10:00 A. M. Meeting of the six scientific sections with probably four papers of twenty minutes each to be presented in each section.

12:00 Noon. Adjournment.

On *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the Council *approved* the general set-up and suggestions from the Program Committee and granted authority to the Program Committee to modify or adjust the program to meet unexpected problems or contingencies.

PROBLEMS OF MEDICAL CARE TO THE NEEDY UNEMPLOYED

Dr. Stone, the chairman of the Policy Committee, reported in detail on a conference held with officials of the State Emergency Relief Commission on the preceding day and on the discussion at a conference of the Policy Committee on the preceding evening. A review was presented on questions raised and recommendations made in the report and resolutions adopted by the Council at its last meeting on October 29, 1933, and submitted on the following day to the State Relief

Commission. (Pages 780 to 783, December, 1933, *Journal.*)

Dr. Stone also reviewed the attitude as expressed in correspondence from component county medical societies pertaining to numerous angles on this general question, as well as experiences to date in other states in the application of federal-state funds in providing medical care to the needy.

Several members of Council discussed these questions at length.

The Chairman of the Policy Committee, Dr. Stone, then submitted for the consideration of the Council the following statement as a basis for consideration:

REPORT ON MEDICAL CARE OF THE NEEDY

The medical profession realizes keenly the need for adequate medical care to the needy unemployed and wishes to cooperate with the State Emergency Relief Commission in evolving a practical procedure.

While we still adhere to the principles and policies adopted by the Council of the Ohio State Medical Association on October 29, we realize the practical difficulties as expressed by the Relief Commission in administration of an adjustable, variable fee schedule in different communities.

We feel that every possible effort should be made to preserve the family and family-physician relationship and the free choice by the needy sick of their medical attendants.

Physicians have been making sacrifices for many months and are still willing to make necessary contributions during this emergency. We believe, however, that the temporary medical fee schedule announced on September 20 by the State Emergency Relief Commission is woefully inadequate and does not cover the "overhead" in practice.

We request that the State Relief Commission make an effort to secure funds to provide a nearer approximation to the costs of other necessities provided to the needy.

We recommend, therefore,

(a) That the fee schedule for services to the needy unemployed during the present emergency be adjusted to approximately two-thirds of average fees which would be expected from persons in moderate circumstances, with the further understanding that such recommended fee schedule not be considered a guide for services to pay patients;

(b) That the present fee schedule of the Relief Commission be adjusted at $1.00 for office calls, $2.00 for home calls (between 7:00 A. M. and 9:00 P. M.), $3.00 for night calls (between 9:00 P. M. and 7:00 A. M.), plus actual costs of medicine and plus mileage at the rate of 25 cents a mile in excess of one mile from the physician's office during daytime hours and one mile from the physician's home for night calls;

(c) And that items f. g. h. and i. under paragraph headed "Schedule" in State Relief Commission of Ohio Supplement No. 1, to Federal Relief Administration Rules and Regulations No. 7 of September 20, 1933, be continued as stipulated in the original.

On *motion* by Dr. Huston, seconded by Dr. Caldwell and *carried*, the foregoing report was adopted as an official policy and statement by the Council. Such motion also included approval of the detailed verbal report submitted by Dr. Stone and Dr. Cummer on this matter.

PROBLEMS OF COMPENSATION AND MEDICAL CARE UNDER CWA

On behalf of the Policy Committee, Dr. Stone, chairman, reported at length on developments under the Civil Works Administration, including the transfer of several thousands able-bodied heads-of-families from the "relief" rolls to the status of "federal employes" under the Civil Works Administration construction program.

He reported that approximately 200,000 had already been put to work in Ohio as a part of the CWA program.

The discussion and report presented problems in connection with medical, surgical and hospital care of those employes of the CWA injured in the course of employment. Dr. Stone also discussed and analyzed the difference between beneficiaries of the Federal Emergency Relief Administration and employes of the Civil Works Administration and the Public Works Administration, the latter of which when injured are in the status of local or industrial employes, compensation and medical care for such injuries coming under the State Workmen's Compensation Law as contrasted with the application of the Federal Compensation Act to "federal employes" under the CWA.

Regulations and variations in the administrative set-up were discussed, and it was agreed that an analysis of these matters be carried as a news article in the January issue of *The Ohio State Medical Journal* for the information of the membership.

WORKMEN'S COMPENSATION DEVELOPMENTS

Dr. Hein, the chairman of a special committee, reported in detail on a conference held with the Industrial Commission on November 15 in an effort to secure improvement in administrative procedure in the handling of workmen's compensation cases, and to secure more prompt payment of medical fees in such cases.

In the course of the report, Dr. Hein discussed factors in regard to prolonged delays in the payment of medical bills, the delay or neglect in answering correspondence addressed to the Industrial Commission and its departments from physicians, failure in the routine system in the issuance of payments even in many cases completed and approved for payment, delays in responding to questions from physicians for authorization for special treatment in unusual cases, failure to make definite explanation to physicians when fee bills are cut, failure in some cases of employers to transmit medical-only reports to the Commission and the failure to proceed against physicians and others who violate the law and regulations or who submit false or fraudulent claims.

Dr. Hein, and Dr. Bigelow, a member of the committee, reported on the cooperative spirit evi-

denced by the Industrial Commission in an effort to improve administrative procedure, as well as on plans to speed up the handling of cases. Other members of Council participated in the discussion. The Council received and *approved* the report.

X-RAY DEVELOPMENTS IN HOSPITAL CONTRACTS IN WORKMEN'S COMPENSATION CASES

Dr. Bigelow, chairman of the special committee on hospital contracts in workmen's compensation cases and especially involving problems of *X*-ray service, reported on a series of conferences and a mass of correspondence. He reported in detail on a conference held with officials of the Medical Department of the Industrial Commission on November 21, at which Dr. E. L. Harmon, Cleveland, chairman of a special committee of the Ohio Hospital Association, was present. Attention was called to the joint report and recommendations of the committees of the Ohio Hospital Association and the Ohio State Medical Association to the Industrial Commission based on approval and action of the Council (page 647, October, 1933, issue of the *Ohio State Medical Journal*). Developments and various conflicting interpretations of the recommendations were reported to the Council.

The Council requested the committee to continue its negotiations with the Ohio Hospital Association and the Medical Department of the Industrial Commission.

NEW HEADQUARTERS LOCATION

Dr. Platter, chairman of a special committee appointed by the President, reported on deliberations by a special committee consisting of himself, Dr. Beer and Dr. Upham, relative to a new location for the State Association headquarters. The committee recommended that the offices be moved to Suite 1005 Hartman Theatre Building, Columbus.

On *motion* by Dr. Platter, seconded by Dr. Paryzek and *carried*, the Council authorized the officers of the State Association to sign a five-year lease for the recommended location.

HOSPITAL GROUP INSURANCE PLANS

Dr. Stone, Dr. Cummer and Dr. Paryzek reported on developments in Cleveland relative to a proposal by the Cleveland Hospital Council for the inauguration of a group hospital payment plan in that city. Details of the plan were analyzed and discussed by members of Council.

Attention was called to an analysis of the preliminary, tentative plan for group hospitalization inaugurated by the Cleveland Hospital Council and published on pages 714 to 717 of the November, 1933, issue of *The Journal*.

Attention was also called to the official statement and policy adopted by the Council of the State Medical Association at its last meeting on the general subject of group hospital insurance payment plans and published on page 777 of the December, 1933, *Journal*.

Dr. Caldwell and Dr. Smith reported on a proposal pending in Cincinnati formulated by a group of laymen for a "budget association" the idea being to sell memberships at annual fees which would entitle the members or "policy holders" to medical and surgical care by local physicians who constitute the professional membership of the association based on their acceptance into membership on the payment of fees.

Several members of Council discussed various angles and problems in such a proposal.

On *motion* by Dr. Smith, seconded by Dr. Shanley and *carried*, the Council referred this matter to the Policy Committee with a request for investigation and report.

SPECIAL PROBLEMS OF POLICY AND LEGISLATION

Dr. Stone, chairman of the Policy Committee, discussed at some length various public developments—legislative, governmental and social—directly affecting medical practice. Supplementing that general report, he submitted in writing a report on several specific matters as follows:

1. *Medical Features of Liquor Control Legislation*

Under national prohibition physicians were able to prescribe limited quantities of liquor for medicinal purposes. In the present efforts of the Ohio Legislature to adopt the best compromise method of dispensing liquor, this professional right of the physician to dispense and prescribe liquor should be recognized and safeguarded, even in those sections of the State which may elect, through local option, to remain dry areas. Likewise, this state liquor control legislation should provide for the securing by physicians of alcohol for scientific and professional purposes.

2. *Medical Examination Features of Barbers' License Act.*

The act creating the State Board of Barber Examiners and regulating the business of barbering contains the following provision: "To such application (for barber's license) shall be attached the certificate of a licensed physician stating that after careful clinical and laboratory examination he finds such applicant to be not affected with any contagious, infectious or communicable disease".

The State Department of Health has given the following opinion on this matter: "The physician who is making a physical examination of an applicant for barber's license should first get a complete medical history of the applicant and should then make a thorough physical examination, in so far as such physical examination is necessary to determine the existence of a contagious, infectious or communicable disease. If a study of this history and the clinical examination give no evidence of the need of laboratory tests and the physician is satisfied that no such disease exists and can so certify over his signature . . . the submitting of specimens for laboratory tests would not be necessary". Furthermore "such specimens should not be sent to the state laboratory unless the physician is satisfied that the applicant is in indigent circumstances. In all other cases, the laboratory specimens should be sent to a reliable commercial laboratory." (O. H. N., Dec. 1, 1933.)

There is nothing in the act governing the cost of the examinations, the reasonable supposition being that the barber applicant would be considered as any other patient demanding a similar service. In some communities, however, physicians

are reported to have solicited this work at a definite fee, and such solicitation is deemed to be unethical.

3. *Anticipated Problems Affecting the Medical Profession in the Special Taxation Session of Ohio Legislature, January, 1934.*

An assemblage of excerpts made of state income tax laws shows 20 states or territories imposing a tax on all classes of income, and two additional states imposing a tax on intangible property. Most of the states provide for exemptions of varying amounts, as is the case with the United States income tax. Rates range from 1% of the first thousand dollars income above exemption to 7% on income in excess of $12,000—each state having its own schedule of income tax levy.

A similar assemblage of excerpts reveals that 19 states have widely varying types of state sales tax laws, including four states which tax personal services as well as retail sales. Two states have an occupational tax on physicians and one of these has the state income tax also.

Numerous new tax proposals will be submitted to the special tax session of the Legislature in January. These proposals must be considered with an effort to avoid a duplication of tax impositions placed upon physicians.

On *motion* by Dr. Huston, seconded by Dr. Caldwell and *carried*, the Council approved the report of the Policy Committee.

CONSTITUTIONAL AMENDMENT RELATING TO MEDICAL ECONOMICS

Dr. Platter, chairman of the Judicial Committee of the Council, submitted for consideration a communication and a pending amendment to the Constitution of the Ashland County Medical Society.

It was pointed out by Dr. Platter, Dr. Huston, Dr. Cummer and others that the Council had previously approved and recommended that each component county medical society create a committee on economics, civics or public relations for the purpose of keeping informed on developments affecting the economic status of physicians, particularly local action by public officials or non-official groups affecting the practice of medicine and including such problems as socialized medicine, the care of indigents as a part of governmental responsibility, and similar matters.

While the Council approved of the general purpose contemplated by the pending amendment to the Ashland County Medical Society's Constitution, it was the consensus of opinion that detailed functions and duties should not be written into the Constitution, that either by amendment to the By-Laws or by resolution of a county society, such a committee could be created. It was decided, therefore, to make such recommendation to the Ashland County Medical Society. The point was made, however, that in case that society prefers to incorporate a detailed proposal in its Constitution, such amendment is not in conflict with the Constitution and By-Laws of the State Association.

Dr. Brush, the acting secretary, having left the meeting, the President designated Dr. Smith as secretary pro-tem.

BUDGET AND FINANCE

Dr. Hein, the chairman of the Committee on Auditing and Appropriations, submitted the following report and recommendations including the proposed budget for the Ohio State Medical Association for the calendar and fiscal year of 1934:

REPORT AND RECOMMENDATIONS OF AUDITING AND APPROPRIATIONS COMMITTEE

The Ohio State Medical Association in common with all other organizations has been confronted during the past year with financial problems. Fortunately, our membership has been maintained at a higher percentage than in any other similar organization on which this committee has information.

We are fortunate, indeed, that the membership has maintained its interest and has realized the importance and necessity of a strong concerted organization, and we are hopeful that losses in membership and consequent revenue during the coming year may be minimized.

As anticipated at the beginning of 1933, the advertising revenue to *The Journal* was substantially reduced from preceding years, but through most advantageous printing contracts, the loss in advertising revenue was largely neutralized.

It is possible that "operating costs", particularly in regard to *Journal* printing, other printing, supplies and maintenance, will be increased during coming months. Already costs of paper, printers' wages, and office supplies have been materially increased, and anticipated costs cannot be definitely anticipated or "fixed" for the succeeding months. Due to the economic forces under the National Recovery Act, possible monetary inflation and the lowered value of the dollar in relation to commodities, it is possible that during the coming year, in spite of all economies and precautions, we may be required to utilize at least a small sum from our reserve.

This committee is especially pleased to report at this time that in spite of adverse conditions during recent months, we have not only kept our expenditures well within our budgetary allowance provided by the Council at the beginning of 1933, but we have been able to accumulate approximately the average yearly balance maintained over a period of the past fifteen years to add to our reserve accumulation. (At the end of 1933, according to our best estimates, we may be able to add about $4,000 to our reserve—income over expenditures for the calendar year 1933).

Economic and governmental developments affecting medical practice during the past year have added exceedingly heavy burdens to our committees and particularly to our headquarters staff, including a prolonged and difficult legislative session, and all of which have been in addition to the multiple details and heavy routine even in normal times. Under ordinary conditions the Council probably would have added to our headquarters personnel, but on account of the uncertainty of the future, the present machinery of organization has been heavily loaded and speeded up.

On account of the threat of sudden and radical changes in governmental policy, social structure and economic confusion, questions directly affecting the medical profession are acute and difficult, emphasizing the relatively greater need at the present time for a strong and harmonious medical organization than ever before. This means that we must maintain an adequate budget to keep organization machinery at its maximum efficiency, and in order to be of the greatest possible service to the membership. In fact, if we find it necessary

to reach into our reserve for expenditures during the coming year, we may assume that such action is thoroughly warranted by the circumstances. Indeed, our reserve is intended to meet such emergencies as we may now anticipate.

As previously indicated and due to careful fiscal supervision and efficient management in our headquarters office, disbursements for the current year of 1933 have been kept well within the authorized budget. Every precaution and safeguard was maintained to protect and add to our accumulated balance. All inactive funds in savings accounts or otherwise were converted into government bonds. Funds that would be required before the end of the year were placed on short-time deposits from which source the Association benefited by accrued interest until such funds were needed.

In accordance with custom, the Auditing and Appropriations Committee employed a certified public accountant to audit the records and financial transactions of the Association for the preceding calendar and fiscal year, which constituted a part of the last annual report of this committee, published in the September, 1933, issue of *The Journal*. A similar complete and official audit will, of course, be made after the end of the present fiscal calendar year.

As a part of the duties of the Auditing and Appropriations Committee, all bills were carefully examined and no vouchers were issued until after official approval. Special attention was given to accurate and efficient maintenance of records. The new Chairman of this committee, appointed at the last Council meeting in October, desires to commend and express appreciation to the thorough and careful precedent in regard to financial details so well maintained by the preceding Chairman.

The accompanying proposed budget for 1934 with comparative list of the budget authorized and appropriated for 1933 in parallel columns, is recommended by the Auditing and Appropriations Committee for the consideration of the Council:

	1934 Recommended App'n.	1933 App'n.
Ohio State Medical Journal	$7,000	$7,000
Medical Defense	4,000	4,000
Committee on Public Policy	800	800
Executive Secretary Salary	6,600	6,600
Executive Secretary, Expense	800	800
Asst. Executive Sec'y, Salary	4,000	3,850
Asst. Executive Sec'y, Expense	200	200
President, Expense	400	300
Treasurer, Salary	300	300
Council, Expense	600	600
Annual Meeting	500	500
Auditing and Appr'n Com.	100	100
Misc. Committee Expense	600	500
Stationery and Supplies	600	600
Postage and Telegraph	700	600
General Counsel	2,100	2,100

AUDITING AND APPROPRIATIONS COMMITTEE
B. J. HEIN, Chairman, Toledo,
H. V. PARYZEK, Cleveland,
S. J. GOODMAN, Columbus.

On *motion* by Dr. Caldwell, seconded by Dr. Smith and *carried*, the Council adopted the foregoing report and approved and authorized the budget as recommended to cover expenditures of the State Association for the calendar and fiscal year of 1934.

Supplementary matters of finance being proposed and considered, on *motion* by Dr. Seiler, seconded by Dr. Huston and *carried*, the Council authorized an appropriation of $150 to apply on expenses incurred in connection with moving the headquarters office and the purchase of necessary equipment. This motion also included the authorization and approval of an increase of $5.00 on the monthly salary of Miss Helfrich of the headquarters staff for 1934, from *The Journal* appropriation.

The question of necessary expenses in connection with the entertainment of the annual meeting of the American Medical Association in Cleveland next June, was presented for consideration and discussion, following which, on *motion* by Dr. Seiler, seconded by Dr. Caldwell and *carried*, the Council authorized the underwriting of expenses of the Committee on Arrangements to the extent of $2,500.

PROGRAM OF CHILDREN'S BUREAU OF U. S. DEPARTMENT OF LABOR

Dr. Southard reported at length on conferences and communications concerning the plans and proposals by the Children's Bureau of the U. S. Department of Labor, based on the "Child's Health Recovery Conference" including a program for nutritional betterment and the employment of welfare workers and nurses.

Problems in connection with official health administration and private medical practice were analyzed in detail by various members of Council. Dr. Southard explained the attitude and policy of the State Department of Health on these matters as being in line with the established policies of medical organization.

On *motion* by Dr. Caldwell, seconded by Dr. Paryzek and *carried*, the Council approved the procedure of Dr. Southard and expressed confidence in his attitude and activity in this matter.

MEMBERSHIP MATTERS

Dr. Cummer, the President, urged the Councilors to make special efforts to emphasize to the membership in their respective districts the vital importance of maintaining their membership and the prompt payment of 1934 dues in these times of sudden changes, important governmental developments and social upheaval directly affecting medical practice. He read a communication from Dr. D. B. Lowe, Akron, urging that greater effort be made to secure a fuller attendance by the members of the House of Delegates at the business procedures during future annual meetings. Dr. Cummer also submitted figures showing a total of 5,166 members in the State Association to date for 1933, compared with 5,342 on the same date last year and with the total for the year 1932 of 5,352. The data also showed a payment to date in advance for 1934 dues of 793 members as compared with those paid in advance on the same date last year of 370. Members of the Council indicated their interest and willingness to make a special

effort between now and the end of the month in urging the payment in advance of 1934 dues.

MISCELLANEOUS

There was submitted for the consideration of the Council a communication from Dr. Olin West, General Manager and Secretary of the American Medical Association, calling attention to the ineligibility of Dr. D. H. Morgan, Akron, as an official alternate from the Ohio State Medical Association to the House of Delegates of the American Medical Association for the coming annual meeting in Cleveland.

Dr. Shanley nominated Dr. Carl R. Steinke of Akron to fill this vacancy as official alternate to the A. M. A. The nomination was seconded by Dr. Seiler. Other nominations being called for and none being made, on *motion* by Dr. Klotz, seconded by Dr. Caldwell and *carried*, Dr. Steinke was officially elected as an alternate-delegate from the Ohio State Medical Association to the House of Delegates of the American Medical Association for a term expiring at the 1934 annual meeting of the State Association.

A communication was submitted for information of the Council from Margaret Sanger of the Annual Conference on Birth Control and National Recovery, to be held in Washington, D. C., January 15 to 17. No action was taken.

There was submitted for consideration a communication from Dr. Bauer of the Bureau of Health and Public Instruction of the American Medical Association, relative to recommendations for committees on mental health. On *motion* by Dr. Paryzek, seconded by Dr. Huston and *carried*, The Council accepted Dr. Stone's report and decided to await a request or recommendation from Dr. E. J. Emerick, a member of the committee of the American Medical Association on this subject.

New business, unfinished business, comments, suggestions and criticisms being called for and no further business being presented, the Council adjourned to meet at the call of the President.

Signed E. R. BRUSH, M.D.,
Acting Secretary.
PARKE G. SMITH, M.D.,
Secretary Pro-Tem.

Three oldest members of the Past Presidents' Association of the Summit County Medical Society were elected honorary presidents at the recent banquet of the group at the Mayflower Hotel, Akron. Those honored were Dr. D. S. Bowman, Dr. J. H. Seiler, and Dr. S. J. Wright. The election of officers for 1933-34 resulted as follows: President, Dr. Joseph Weller; vice president, Dr. C. E. Held, and secretary, Dr. J. H. Seiler. Following the dinner, the group, which consists of 25 past presidents of the Summit County Medical Society, was addressed by Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council of the American Medical Association, on "The Practice of Medicine—Profession or Trade".

Plan for Employment of More Nurses on Shorter Hours is Inaugurated

Cooperation of the medical profession of Ohio in a program launched by the Ohio State Nurses' Association to have inaugurated an eight-hour-day schedule for special duty nurses has been requested by the Board of Trustees of the Ohio State Nurses' Association.

Mrs. Elizabeth P. August, general secretary of the nurses' association, in a recent statement expressing the hope that the physicians of Ohio would assist that organization in this state-wide effort to spread employment among nurses, many of whom are confronted with critical financial difficulties because of prolonged unemployment, pointed out that many hospitals of the state have adopted the shorter-hours plan and that others are ready to put the eight-hour plan into operation as soon as minor details can be worked out. The primary purpose of the plan is to give employment to more nurses but with shorter hours for each at no increase in expense to patients.

"The eight-hour plan for special duty nurses has met with the approval of practically every hospital superintendent who has been informed of its benefits," Mrs. August declared. "Naturally, the various nurses' organizattions are in favor of it.

"At present, one of our primary objectives is to obtain the active interest, support and cooperation of the physicians of Ohio in our attempt to partially solve a serious situation among nurses. We realize that the physician can do much to assist in making this program of placing more nurses at work a success and we are hopeful that our request for state-wide cooperation from the medical profession will be granted.

"Spread of employment among private duty nurses called for hospital duty is being met through the cooperation of hospital managements.

"Now, one of our biggest tasks is to place special duty nursing in homes, as well as hospitals, on an eight-hour basis. The physician can be especially helpful by assisting us in 'selling' the idea to the public and by advising his patients in need of special duty nursing as to the benefits of this program for all concerned.

Mrs. August called attention to the fact that although the movement launched as long ago as 1925 by the American Nurses' Association to reduce the number of nurse training schools and curtail the annual production of nurses has done much to remedy the chaotic condition in the nursing field, obviously it has not been able to meet the situation which has developed as a result of the economic depression and widespread unemployment in all fields.

To meet this increased unemployment among nurses, the eight-hour day plan has been inaugurated and has spread rapidly throughout the country, she said, pointing out that at present 150

hospitals have placed it into effect and that in many localities it is being used for private duty nursing in the home.

The outstanding advantages of the eight-hour day plan are, according to Mrs. August:

1. More efficient nursing care for the patient;
2. Added employment for nurses;
3. Satisfactory leisure time and an opportunity for professional and cultural growth for special duty nurses.

Mrs. August emphasized that under the eight-hour plan recommended by the Board of Trustees of the Ohio State Nurses' Association, *nursing service would cost the patient no more than under the 12-hour, two-shift plan.*

"We have recommended," Mrs. August said, "that nurses employed on an eight-hour basis receive 50 cents an hour or $4.00 per eight-hour day. This is the same hourly rate paid nurses on 12-hour duty who receive $6.00 for 12-hours service. Obviously, adoption of the eight-hour plan at the 50-cents-per-hour rate will not increase the cost of nursing service for the patient. It will mean a decrease in the daily income of the employed nurse but will spread employment in such a way that she will work more hours per year, resulting in an increase in her average yearly income."

Commenting on the fact that approximately 1050 nurses took the examinations for certificates to practice given in December by the nurses examining committee of the State Medical Board, Mrs. August said:

"It is quite unlikely that such a large number of nurses will apply for certificates in future years. Many nurse training schools have been closed and the qualifications for entrance into nurse training schools have been raised.

"Anyway, our immediate problem is to try to supply work for those nurses who have been admitted to practice and are now seeking employment.

"That is one reason the Ohio State Nurses' Association has approved the eight-hour program and why it is soliciting the support of the physicians of the state in this movement."

In an article in the December, 1933, issue of *The American Journal of Nursing*, Ethel Swope, R.N., reviewed some of the benefits of the eight-hour schedule from the standpoint of patient, nurse and hospital, following a nation-wide survey of the results of the program.

"Proof of satisfaction to the patient of the shorter relay for the special duty nurse is frequently requested," according to Miss Swope.

"The satisfaction of the patient is indicated in the reports of directors of nursing in those hospitals in which the eight-hour plan is functioning. The records show that approximately 98 per cent of the patients approve the eight-hour day because, according to the statement of the patient, better nursing care is received due to lack of fatigue on the part of the nurse."

Miss Swope discussed in detail the eight-hour plan from the standpoint of the physician.

"Repeatedly the statement appears in the record," she said, "that previous to the inauguration of the eight-hour relay a portion of the medical staff opposed the change from the twelve-hour schedule. Reports, however, show that prior to the starting of the eight-hour day the physicians were opposed to the plan; since the eight-hour relay has functioned the physicians not only approved the schedule, but prefer the system of shorter hours because of the better nursing which the patient receives.

"Investigations prove that the physicians desire nurses who are progressive, who can readily interpret orders, and who are educationally, culturally and physically prepared to give satisfactory nursing care in the constant attendance of his patient. Basically, the physician has but one ambition for his patient, i.e., that he may etsablish a speedy recovery, and any system which will assist in the restoration of the health of the patient will, it is believed, receive his complete consideration."

The Committee on Industrial Medicine and Traumatic Surgery of the American College of Surgeons has presented in outline form to the National Recovery Administration a medical code for industrial employers. It provides that all industrial medical clinics be required to conform to specific standards; all new employes have pre-employment examinations and all employes annual health examinations; industries establish individual or joint pathological and *X*-ray laboratories; defects revealed by examinations be cared for by industry insofar as they come within the scope of workmen's compensation statutes, and otherwise be referred to the family physician of the employe; insofar as possible the facilities of industrial laboratories be made available to family physicians of employes; industries should utilize hospitals which are properly equipped and standardized.

Ira J. Dodge, superintendent of the Huron Road Hospital, Cleveland, formerly superintendent of the Marietta Memorial Hospital, died November 15 at Washington, D. C. of pneumonia.

Wilmington—Dr. Elizabeth Shrieves recently addressed the girl students of Wilmington College.

Cincinnati—Dr. George Irvin, Orrville, was elected president and Dr. Charles Geiser, Cincinnati, first vice president at the recent meeting of the Southern Homeopathic Medical Association here.

Columbus—Dr. Rollo C. Baker has been elected chairman of the department of anatomy, Ohio State University, succeeding the late Dr. Francis L. Landacre.

PROBLEMS OF MEDICAL CARE TO PERSONS DISABLED ON CIVIL WORKS PROJECTS

Persons employed in Ohio on Civil Works projects, now totaling more than 200,000, who are disabled through injuries received in or sickness arising from such employment are to be paid compensation during the period of disability and are to be provided with medical attention at government expense, the Ohio Civil Works Administration has announced.

In compliance with a uniform procedure adopted by the Federal Civil Works Administration, compensation benefits and medical services as provided by the United States Employes' Compensation Act of 1916, as amended, are established from a special fund set up by the Civil Works Administration.

Administration of the fund is being handled by the United States Employes' Compensation Commission under the rules and regulations promulgated pursuant to the enactment of the Federal Compensation Law 17 years ago and governing compensation and medical benefits by the Federal government to its disabled civilian employes.

Ohioans who had previously been on the temporary emergency relief rolls but who are now employed on Civil Works projects at an average weekly wage of $15.00, have the status of "civilian employes of the Federal government" as all Civil Works projects are being financed by Federal funds.

The Civil Works Administration program should not be confused with the Public Works Administration program.

The Civil Works program provides for the direct payment of employes by the Federal government on projects under the control and supervision of the Ohio Civil Works Administration (the personnel of which is the same as the State Relief Commission) and directly supervised by a Civil Works Administrator in each county.

The Public Works program provides for the allotment and loan of Federal funds to political subdivisions for the performance of work by contract. Employes of private contractors who are injured on projects coming under the Public Works program and financed largely (approximately two-thirds) by local funds are to be compensated in the usual manner by the State Industrial Commission and provided with medical care under the Ohio Workmen's Compensation Law out of the state workmen's compensation fund.

MEDICAL PROVISIONS OF U. S. LAW

The United States Employes' Compensation Act and the rules and regulations issued pursuant thereto by the United States Employes' Compensation Commission governing compensation and medical services for all civilian Federal employes, including the approximately 4,000,000 person now employed on Civil Works projects, are specific and definite regarding the type of medical service which shall be provided for disabled employes and what medical facilities shall be utilized.

Under the provisions of Section 9 of the United States Employes' Compensation Law, medical services, appliances and supplies for injured civilian employes of the United States "shall be furnished by or upon the order of United States medical officers and hospitals but where this is not practicable they shall be furnished by or upon the order of private physicians and hospitals designated by the commission" (United States Employes' Compensation Commission).

The rules and regulations of the Commission provide for the selection of "designated physicians and Government medical facilities in various towns and cities for the treatment of injured employes", but they further provide that "in localities where neither Government hospitals or dispensaries nor designated physicians are in the vicinity the injured employe or his official superior should secure treatment from the nearest available competent physician licensed to practice medicine and surgery" and that "such physician need not be given any specific authority for treatment but should be informed that the Commission will settle all reasonable charges for fees not in excess of those prevailing in that locality for patients receiving the average income of government employes".

HOW MEDICAL FACILITIES ARE PROVIDED

The Ohio Civil Works Administration has stated that insofar as practicable the provisions of the United States Employes' Compensation Law and the regulations of the Federal Compensation Commission relative to medical services for injured Civil Works employes will be enforced in Ohio.

In compliance with the provisions of the United States Employes' Compensation Law and their adaptation to Civil Works employment, disabled Civil Works employes will be sent to United States medical officers, Federal hospitals or dispensaries, or physicians who are designated by the Federal government to provide medical care for disabled civilian employes of the Federal government when such medical facilities or designated physicians are available in the town or vicinity in which the injured person is employed.

Where Federal medical facilities or designated physicians are not available, other public medical facilities, either state, county or municipal, can be utilized.

In localities whether neither Federal nor other public medical facilities or designated physicians are available, local Civil Works Administrators have been authorized to arrange for medical care from private physicians.

Designated physicians or private physicians and hospitals will be paid "reasonable fees" for their services, such fees to be "not in excess of those charged patients in the same income class as the injured person". The present uniform medical fee schedule applying to cases coming under the Ohio Workmen's Compensation Law has been cited to County Civil Works Administrators by the Civil Works Administration as a tentative guide for charges made for medical services to disabled Civil Works employes.

USE OF PRIVATE PHYSICIANS URGED

The desirability of establishing a procedure which would permit Civil Works employes to select their own physicians in communities where there are no Federal medical facilities or designated physicians has been emphasized to the Ohio Civil Works Administration by representatives of the Ohio State Medical Association.

It has been pointed out to the Civil Works Administration that now when the number of Federal civilian employes in Ohio has been greatly multiplied by the employment of approximately 200,000 persons on public works, the small number of physicians (about 150) previously designated to furnish medical care to Federal employes will be entirely inadequate in most communities to care for those injured while employed on Civil Works projects but that a sufficient number of private physicians is available in every section of the state.

Moreover, it has been pointed out that Federal hospitals and dispensaries are available in only a few localities in Ohio while almost every county is supplied with adequate private hospital facilities.

A point especially stressed to the Ohio Civil Works Administration is that physicians in every community where public works are now under way have been rendering medical care to the needy unemployed for a considerable time and in most instances without compensation, especially to patients who came to them and paid for services when previously employed, and that now it is only right and desirable that this family-physician relationship be maintained wherever possible and that those employed on Civil Works projects be permitted to obtain medical care for injuries while at work from their regular family physician when the Federal law and regulations permit.

Most of the 150 Ohio physicians who have been on the list of 4,000 physicians designated by the Federal government to render medical services to disabled civilian Federal employes are located in the larger cities and more populous sections of the state. In only a few vicinities are Federal hospitals or dispensaries available.

LOCAL CONTACTS IMPORTANT

Although in some instances the Ohio Civil Works Administration may find it necessary to designate additional physicians to assist those already on the Federal list of designated physicians in the care of injured Civil Works employes, it is possible that in communities having neither Federal medical facilities or designated physicians the matter of providing medical services for disabled Civil Works employes will be left to the County Civil Works Administrator who may, if he desires, permit such employes to go to their own physicians.

For this reason, it is important that representatives of each county medical society confer immediately with the Civil Works Administrator of that county on this matter and emphasize to him the reasons why the free choice of medical service by Civil Works employes should be permitted whenever possible.

The local Civil Works Administrator or his agent is required to follow up cases under private medical care, to secure medical reports, and to endorse each voucher for medical services before it is forwarded to the United States Compensation Commission, and to certify that the services covered therein have been rendered to the injured person.

Private physicians who already have treated injured Civil Works employes should submit an itemized fee bill to their local Civil Works Administrator as soon as possible so that the proper forms and papers can be made out and the bill sent to Washington for approval and payment.

Forms for various kinds of claims must be filled out. Information regarding these may be obtained from local Civil Works Administrators.

ADDITIONAL PROVISIONS OF REGULATIONS

Following are some of the additional pertinent provisions of the rules and regulations of the United States Compensation Commission which have been adopted in connection with medical services for Civil Works employes:

Employes are entitled to medical treatment only for injuries sustained while in the performance of duty and occupational disease, i.e., those showing direct casual relationship to the nature and conditions of employes' work. The common diseases, such as colds, pneumonia, tuberculosis, typhoid fever, rheumatism and the like can very rarely and only under most unusual conditions be the basis of an award under the Federal Compensation Law.

Treatment by osteopaths, limited practitioners, mental healers, etc., will be paid for only when such treatment is especially prescribed by a physician licensed to practice medicine and surgery and approved by the commission.

Provided an injured employe has received proper notice of the medical and hospital treatment which is at his service, any other medical service which he may secure will be at his own

LAUNCHING of the Civil Works Program in Ohio, giving employment to approximately 200,000 persons, has greatly reduced the number of persons and families who had been entitled to medical services from federal-state funds under the Federal Emergency Relief Program (Regulations No. 7), detailed information regarding which has been published in the past several issues of *The Journal*.

Most of the persons now employed on Civil Works projects at weekly wages approximating $15.00 had previously been carried on the emergency "relief" rolls and had been entitled to medical care at Federal expense, for which service greatly reduced fees to physicians have been authorized by the State Relief Commission.

Men and women who have been placed on the payrolls of the Civil Works Administration have been automatically taken off the relief rolls, and have reverted to the status of ordinary patients insofar as disabilities *not* incurred in the course of or resulting from their employment.

Physicians who attend an employe for disabilities *not* incurred in his employment must look to such employe for payment unless the employe is so situated that the wages he receives are inadequate to pay for medical services for himself and dependents.

Although some persons employed on Civil Works projects may be able to support themselves and families from their Civil Works wages it is unlikely that all those who have been taken off the relief rolls will be able to provide themselves and their families with food, clothing, fuel, shelter and medical service.

If a Civil Works employe finds himself unable to provide necessities, including medical service, for himself and dependents he may apply to the local relief administration. If the relief administration determines that the situation of the applicant warrants the furnishing of necessities at public expense, it is authorized to make arrangements to furnish them. Whether this will be done by placing the applicant again on the relief rolls or in some other way is a matter for local determination. Even if a person is able to provide himself and his family with food, clothing, fuel and shelter but is unable to provide medical service, he may be placed on the relief rolls and needed medical service provided at government expense.

As explained in the accompanying article, those employed on Civil Works projects who are injured or disabled *in the course of or as a result* of such employment will be entitled to compensation and medical service for such disabilities at the expense of the Civil Works Administration.

expense. An employe may refuse the medical and hospital treatment provided but when he does so other medical treatment will not be paid for by the commission.

Whenever an injured employe prefers to be treated by his private physician or hospital, he must report from time to time to the United States medical officer or a designated physician of that locality, if any, for examination to determine whether or not he is entitled to further compensation.

A physician has no authority to extend other than emergency treatment to an employe unless the employe presents an authorization for treatment from his official superior. In case it is impracticable for the employe to obtain a request or authorization for treatment, the physician may furnish temporary treatment but in such instances a proper authorization must be obtained within 48 hours from the employe's official superior.

Cases requiring hospitalization should be referred to a Government hospital where available. If there are none of these hospitals in the vicinity a case may be placed under the care of a designated physician for treatment in a private hospital of his selection.

In all cases of injury where the emergency is such as to require it, any physician licensed to practice medicine and surgery under the state law may be called for first-aid treatment, but further treatment, if required, must be obtained from a United States medical officer or hospital, if available, otherwise from a designated physician, if there is one.

In rendering a bill for first-aid treatment by a private physician obtained under emergency, the injured person or his representative should obtain an itemized statement from the physician rendering such aid. The bill should show the nature of the service rendered and should be indorsed by the official superior showing the bona fide nature of the emergency.

In all cases where medical or hospital services or supplies are to be paid for by the commission, the bills should be forwarded, unpaid, by the claimant, through his official superior or by the physician or hospital furnishing the services or supplies. Payment therefor will be made direct to the physician or hospital.

No injured employe will be furnished treatment in his home unless such arrangement is approved by the commission or unless, in the opinion of the medical officer or designated physician in charge of the case, treatment at home is the only course practicable in the circumstances and the reasons

for home treatment are reported to the commission.

Whenever emergency does not require immediate action, the advice and approval of the medical officer or designated physician should be obtained before the patient is sent to hospital. Ward service only will be furnished by the commission where adequate and suitable ward service is available except in cases requiring care in a private room. When the attending physician certifies to the need for a special nurse, special nurses will be furnished.

Where an injury is of such nature that it can be treated best by a specialist, medical officers and designated physician are authorized to secure his services, either to take charge of the case or as a consultant. A specialist should charge not in excess of the rates prevailing in the locality for such special service for patient the average income of Federal employes. *X*-rays and photographs are authorized in the usual classes of cases requiring such services.

Attending physicians are required to keep adequate records in all cases and to forward to the commission a report of each and every injury treated by them which results in any medical charge against the commission. Medical reports must be submitted as soon as the nature and extent of injury shall have been ascertained. Supplementary reports are required by the commission in cases of requiring hospital treatment, cases of serious injury, cases involving disability for one month or more, etc.

A separate bill is required for each injured person. Each bill should be fully itemized to show the nature and extent and the dates of the services rendered and the unit price and total of the various charges made. No additional fees will be allowed for submission of reports or copies of clinical records. Bills should be submitted upon the termination of service if treatment is of short duration in which case the bill may accompany the medical report, or monthly if treatment extends over a considerable period.

Bills for hospital services, consultants, *X*-rays, anesthetics, medicines appliances, etc., should be approved by the physician in charge. Bills for the personal services of any one other than the person submitting the bill should not be included unless the service were rendered by a salaried employe of the physician or institution submitting the bill. Those rendering service who are not salaried employes of the physician in charge or of the institution should submit separate bills. Bills for professional services from physicians receiving a salary from the Government for full-time service, or whose contracts call for the furnishing of relief under the compensation act, will not be paid by the commission.

If bills for medical service or supplies are paid by the employe, he should submit the itemized bill receipted with the full name of the payee.

Bills for emergency treatment by private physicians where Government medical officers and hospitals or designated physicians are available should be accompanied by a full explanation from the official superior of the circumstances which made it impracticable to use Government or designated facilities.

DECEMBER EXAMINATION QUESTIONS ASKED APPLICANTS FOR MEDICAL LICENSURE

Fifty medical school graduates took the mid-winter examinations for Ohio licenses given in Columbus, December 6, 7 and 8 by the State Medical Board.

Examinations for certificates to practice in Ohio also were given to 12 osteopaths, 7 chiropractors, 1 mechanotherapists, 6 cosmetic therapists, 10 masseurs and 8 chiropodists.

Results of the examinations will be acted upon at the next meeting of the board, scheduled to be held in Columbus on January 9.

Following were the questions asked in the examinations given applicants for licenses to practice medicine and surgery.

CHEMISTRY

1. What is the chemical treatment for carbolic acid poisoning?
2. Name some of the abnormal chemical constituents of urine.
3. Mention three coal tar products extensively used in medicine and prepared in the chemical laboratory by synthesis.
4. Give the chemical difference between cbloral and chloroform.
5. What is glycogen? From what is it derived? What is it converted into by dilute acids?

PRACTICE

1. Give three classes of heart disease according to etiology and state the type of lesion in each.
2. Describe the symptoms and progress of a tuberculous pleurisy. Give treatment in early stage.
3. Give the symptoms and physical signs of a case of broncho-pneumonia in a child of five years. Give treatment.
4. Give the method, dosage and precautions used in administering diphtheria antitoxin.
5. Discuss some of the more frequently found symptoms of encephalitis lethargica, and how you would manage a case.
6. Discuss the treatment of a primary anemia in contrast to that of a secondary anemia.
7. Give the symptoms of hypothyroidism and hypopituitarism and indicate treatment.
8. Give the symptoms of an aneurism of the aortic arch located before the origin of the left carotid artery and discuss medical management.
9. Discuss the symptoms and progress of a case of hepatic cirrhosis (Portal).
10. Discuss privileged communications and their legal import.

BACTERIOLOGY, PATHOLOGY AND HYGIENE

1. Discuss the role of insects in transmitting disease and give an illustration.
2. Give method of differentiating the b. coli communis and the b. typhosus; the streptococcus pyogenes and the gonococcus.
3. Describe the changes in the heart following arterial hypertension.
4. What procedure would you follow as a general practitioner to establish the diagnosis of a suspected case of undulant fever?
5. Describe a primary chancre.
6. How would you differentiate by pathological examination between a benign and a malignant tumor of the breast?
7. What is a hydronephrosis, how produced and terminal results?
8. What is the etiology of two of the more common ulcerations of the lower colon, and discuss their pathologic progress.
9. Discuss the management of an epidemic of scarlet fever among a boys summer camp.
10. Discuss the methods to control an outbreak of "athletes foot" from a community swimming pool.

PHYSIOLOGY

1. Give the distribution and properties of vitamin C.
2. Describe the effects on the pyramidal tracts of acute thrombosis in the internal capsule.
3. Describe the functions and mode of action of the otic labyrinth.
4. In what ways do the respiratory movements affect the

circulation of the blood?
5. List the effects of stimulation and of section of the nerve fibres of the left cervical sympathetic.
6. What would be the physiological effects of gradually increasing the intracranial pressure?
7. Contrast the effects of destruction of the upper and lower motor neurons.
8. Describe the origin of the impulse and its conduction in the human heart.
9. In what ways would you test and measure the efficiency of the cardiovascular system?
10. Discuss the characteristics, functions and origin of cerebrospinal fluid.

ANATOMY

1. Locate the sphenoidal fissure. What nerves does it transmit?
2. Name the bones of the foot.
With what bones does the astragulus articulate?
3. Describe the coronary arteries.
4. Where is the carotid plexus located?
With what does it communicate?
5. What nerves, arteries and veins supply the larynx?

SPECIALTIES

1. Name the different forms of nasal neoplasms.
2. Give the symptoms, treatment and prognosis of otosclerosis.
3. What are the causes of corneal opacities?
4. Give symptoms and physical findings of tuberculosis of the larynx.
5. What is Menieres disease?

DIAGNOSIS

1. Differentiate the following diseases affecting the knee joint:
(a) Charcot joint (b) Sarcoma (c) Tuberculosis.
2. Give the causes of hepatic fever. What other conditions would you consider in a differential diagnosis?
3. Name six causes producing enlargement of the spleen.
4. Classify the causes of hematuria.
5. Describe epidemic poliomyelitis. Give pathology and diagnosis.
6. Differentiate renal colic, gallstone colic and acute appendicitis in a man of 55 weighing over 250 pounds.
7. Discuss neurosyphilis. Give symptoms and differential diagnosis.
8. Give signs and symptoms of the following:
post-operative lung collapse
post-operative intra abdominal hemorrhage
spinal anesthetic shock
9. Differentiate intra capsular and extra capsular fracture of the femur.
10. What are the symptoms of Impetigo contagiosa?

OBSTETRICS

1. Postpartum hemorrhage; give causes, management and treatment.
2 What does it indicate when called to case of labor and you are informed the bag of water has ruptured and the parturient mother has had no labor pains? Outline procedure.
3. When would you use forceps, and how would you apply them?
4. Give your findings in R. O. P. presentation:
(a) abdominal (b) vaginal (c) management.
5. Give management used to give the most painless delivery in a case of L. O. A.

SURGERY

1. A large hernia is found in the scrotum; how can you tell if it's direct or indirect in type?
2. Why is it important in certain cases to remove a stone from the ureter?
3. Fractures of the pelvis shown by X-ray should be examined immediately for what complications?
4. Name the different forms of bone cysts.
5. Name six different causes of gangrene of the lower leg; which of these would you term moist gangrene and which dry?
6. Give the diagnosis and treatment of the following conditions:
(a) brain concussion (b) brain compression
(c) brain laceration
7. Describe Pagets disease of the nipple; give diagnosis, course of metasasis and treatment for breast carcinoma.
8. Discuss:
(a) Phrenectomy (b) Sympathectomy
In what type of cases would you consider them of value?
9. Give differential diagnosis of three types of acute bowel obstruction.
(a) treatment and prognosis of each.
10. Give diagnosis and treatment of penetrating gun shot wounds and stab wounds of the chest.

MATERIA MEDICA AND THERAPEUTICS

1. Phenobarbital; give action, uses, dose and symptoms of overdose.
2. Codein; from what derived? How does it affect respiration? Give uses and dose.
3. Name the preparations of belladona. Give action, uses and dose of each preparation.
4. Give indications for use, modes of administration and strength of normal salt solution.
5. Name the different preparations of veratrum and aconite. Give the uses and dose of each.
6. Write a prescription containing not less than three drugs for a child suffering with entero colitis.
7. Give indications and dose of two remedies used in influenza, acute tonsillitis and acute bronchitis.
8. Name two serums in general use. Give mode of administration and dose of each.
9. Give indications for use of corpus luteum, mode of administration and dose.
10. What is a hypnotic and what is a narcotic? Name three in common use and give dose of each.

MATERIA MEDICA
(Homeopathic)

1. For what gastric symptoms would you prescribe hydrastis?
2. What do you understand by the word Psora?
3. What is the meaning of psychosis?
4. What is a Polycrest? What is a Nosode?
5. What are the symptoms of Silicea in ear disease?
6. From what is Rama-Bufo derived?
7. Differentiate causticum and phosphorus in cough.
8. What are the abdominal symptoms of Mag Phos?
9. What skin condition calls for graphites?
10. What is the difference between a trituration and a dilution?

Medical Examination Under the Barber Law

Several questions have been raised by physicians in communications to the State Association headquarters office and the State Department of Health relative to the physical examination provisions of the State Barber Licensing Law under which applicants for a barber's license must present to the State Barbers' Licensing Board a physician's certificate stating that such applicant is not affected with any contagious, infectious or communicable disease.

One point raised is with regard to the laboratory examination of applicants. Several physicians have raised the question of the liability of the physician should he report an applicant to be affected with a contagious, infectious or communicable disease and such report used by the State Barbers' Licensing Board as the basis for rejection of the applicant.

This question has arisen apparently through a misunderstanding of the data required from the examining physician. The certificate filled out by a physician and filed by an applicant with his application for a license simply states that the examining physician finds after careful clinical and laboratory examination that the applicant is *not* affected with any contagious, infectious or communicable disease. Should the examining physician find upon examination that the applicant *is* affected with some contagious, infectious or communicable disease he should not furnish the required certificate and therefore he could not in any way make himself liable to a suit for damages from the applicant.

Another phase of the examination which has created considerable confusion is that relative to where laboratory specimens should be sent for examination. As pointed out in the December issue of *The Journal*, page 800, laboratory specimens should *not* be sent to the State Department of Health Laboratory by examining physicians unless the applicant comes within the classification

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of indigent. The State Department of Health Laboratory is not authorized to make examination of such specimens unless the patient is in indigent circumstances.

There is nothing in the Barbers' Licensing Law which places any responsibility upon the State Department of Health or local health departments with regard to the physical and laboratory examinations of applicants for licenses. As a matter of fact, all the statute demands is that the health examination certificate be signed by a licensed physician. Naturally health commissioners would not be expected to conduct such examinations in connection with their duties as public health officers.

Due to the large number of inquiries which have been received by the State Department of Health, State Director of Health H. G. Southard has issued the following bulletin regarding the phyical examination aspects of the Barbers' License Law:

"The Department of Health is receiving numerous inquiries relative to the scope of the physical examination of barbers required by Section 9 of the Act creating the State Board of Barber Examiners and regulating the business of barbering. These inquiries have come from health commissioners, physicians, barbers, and from the Board of Barber Examiners.

"The main question raised is in regard to laboratory examinations. Section 9 of the Act contains the following provision: 'To such application (for barber's license) shall be attached the certificate of a licensed physician stating that after careful clinical and laboratory examination he finds such applicant to be not affected with any contagious, infectious or communicable disease.'

"The laboratories of the Department of Health have already received many specimens of blood to be examined for evidence of syphilis, but we have not received other specimens to determine the existence of any other disease. If a thorough 'laboratory examination' is required by the terms of this Act, it would include tests for all contagious, infectious or communicable diseases evidence of the existence of which may be determined by laboratory methods. The term 'laboratory examination' would not be satisfied by an examination for syphilis alone.

"It is the opinion of this department that the physician who is making a physical examination of an applicant for a barber's license should first get a complete medical history of the applicant and should then make a thorough physical examination, in so far as such physical examination is necessary to determine the existence of a contagious, infectious or communicable disease. If a study of this history and the clinical examination give no evidence of the need of laboratory tests and the physician is satisfied that no such disease exists and can so certify over his signature, then in our opinion, the submitting of specimens for laboratory tests would not be necessary.

"Many inquiries have also been made in regard to having these laboratory tests made in the Department of Health Laboratories. In answer to these inquiries we have stated that such specimens should not be sent to the State Laboratory unless the physician is satisfied that the applicant is in INDIGENT circumstances. In all other cases, the laboratory specimens should be sent to a reliable commercial laboratory. There is nothing in this Act that requires the State Department of Health to make these laboratory examinations or places any responsibility upon local health commissioners to have them made.

"The certificate of the health commissioner, found on the application, is to satisfy the Board of Barber Examiners that the physician is licensed and that the signature is genuine."

In connection with medical questions arising from the Barbers' Licensing Law, reference should be made to an official statement adopted by the Committee on Public Policy and submitted to and approved by the Council of the State Association at its meeting on December 17, 1933, as reported in the official minutes of the meeting published elsewhere in this issue of *The Journal*.



Courtney P. Grover, M.D., Dayton; Kansas Medical College, Topeka, 1904; aged 52; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 29. Dr. Grover, a Fellow of the American College of Surgeons, had been a resident of Dayton for the past 22 years. Dr. Grover was a staff surgeon at the Dayton Military Home, until the World War, when he served as a lieutenant colonel in charge of hospital organization work. After serving at the Military Home for a number of years after the war, Dr. Grover entered private practice. He was a member of the American Legion and various Masonic orders. His widow, one son, one daughter, his parents, one brother and one sister survive.

John L. Hervey, M.D., Martins Ferry; Medical College of Ohio, Cincinnati, 1892; aged 66; member of the Ohio State Medical Association and the American Medical Association; died November 15. Dr. Hervey, a resident of Martins Ferry since shortly after his graduation from medical school, is survived by his widow, one son, three brothers and three sisters.

William Hetzler, M.D., Germantown; Medical College of Ohio, Cincinnati, 1884; aged 81; died November 8. Dr. Hertzler, a native of Germantown, had practiced in that vicinity since 1896. He leaves one daughter and two sons.

William A. Knowlton, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1867; aged 94; died November 10 of complications resulting from a fractured hip. Dr. Knowlton, a Civil War veteran retired from active practice several years ago. He is survived by one son and one daughter.

Henry Langholtz, M.D., Oak Harbor; Northwestern Ohio Medical College, Toledo, 1888; aged 74; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died December 8 of heart disease. Dr. Langholtz is survived by his widow and two sons.

Valentine C. Lucas, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1888; aged 66; died November 23. His widow, one son and one daughter survive.

Chalmers J. Penn, Piketon; licensed 1896; aged 81; died November 21 after a brief illness. Dr. Penn, a native of Scioto County, was a former member of the district board of health. He be-

longed to the Masonic Lodge. Surviving are his widow, one son and one brother.

James M. Scoville, M.D., Warren; Western Reserve University, School of Medicine, 1885; aged 74; former member of the Ohio State Medical Association and the American Medical Association; died November 12 following an extended illness. Dr. Scoville had practiced at Warren since 1899. For four years he was Trumbull County coroner and was active in the Masonic Lodge. He leaves one son.

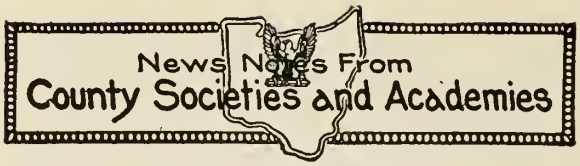
Parker E. Southwick, M.D., Sandusky; Western Reserve University, School of Medicine, 1902; aged 55; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died November 20. Dr. Southwick located in Sandusky in 1903. He had held two terms as county coroner and during the World War served in the medical corps. Dr. Southwick was a member of the Masonic and Elks lodges. His widow, his parents, one sister and one brother, Dr. A. A. Southwick, Cleveland, survive.

Alfred Robinson M.D., Columbus; Miami Medical College, Cincinnati, 1879; aged 82; died November 20. Dr. Robinson, who practiced at Ironton for many years, was a former member of the Ohio General Assembly from Lawrence County and for many years was sergeant-at-arms of that body. He also was a member of the board of trustees of the State School for the Blind. He leaves a grandson and two nieces.

Alfred C. Smith, M.D., Columbus; Starling Medical College, Columbus, 1898; aged 69; former member of the Ohio State Medical Association and of the American Medical Association; died November 19 of pulmonary embolism. Dr. Smith was a member of the staffs of Grant and Mt. Carmel hospitals, Columbus. Surviving are his widow and two sons.

S. Annie Yates, M.D., Cincinnati; Eclectic Medical College, Cincinnati; aged 83; died December 3 of pneumonia. Dr. Yates had practiced in Cincinnati for about 50 years. She was active in literary and philanthropic affairs. Surviving are one son, Major Frederick Yates, of the Medical Corps, U.S.A.

The American Board of Otolaryngology, of which Dr. William V. Mullin, Cleveland, is a director, has announced that the board will hold an examination in Cleveland on June 11, 1934, during the session of the American Medical Association and that an examination will be held in mid-summer in connection with the meeting of the Pacific Coast Oto-Ophthalmological Society. Applicants for the examination should address Dr. W. P. Wherry, 1500 Medical Arts Building, Omaha, Nebraska, for proper application blanks. The last examination given by the board at Boston in September was taken by 79 candidates.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(Harold F. Downing, M.D., Secretary)

December 4—General session. Program: "The Place of the Medical School in the University", Raymond Walters, president of the University of Cincinnati; "The Role of the Physician in Civic Life", Russell Wilson, mayor of Cincinnati.

December 11—General session. Program: "Recent Advances in the Diagnosis and Treatment of Peripheral Vascular Disease", Dr. Louis G. Herrmann; discussion by Dr. Mont R. Reid and Dr. Alfred Friedlander.

December 1—General session. Program: "Continuity", Wade W. Oliver, professor of bacteriology, Long Island Medical College, New York.

Brown County Medical Society held its annual meeting and election of officers on November 22. Dr. R. B. Hannah, Georgetown, was re-elected president, and Dr. George P. Tyler, Jr., Ripley, was re-elected secretary-treasurer.—George P. Tyler, Jr., Md., Secretary.

Clermont County Medical Society elected the following officers for 1934 at its annual meeting on November 15 at Owensville: President, Dr. Allan B. Rapp, Owensville; vice president, Dr. K. B. Hanson, Milford; secretary-treasurer, Dr. J. M. Coleman, Loveland; legislative committeeman, Dr. James K. Ashburn, Batavia; medical defense committeeman, Dr. F. H. Lever, Loveland; delegate, Dr. Rapp; alternate, Dr. Coleman. Dr. Parke G. Smith, Cincinnati, councilor of the First District, was a guest of the society and spoke on organization activities. The scientific speakers were Dr. John Skavlem and Dr. Reed Shank, both of Cincinnati.—J. M. Coleman, M.D., Secretary.

Fayette County Medical Society at its annual meeting on December 7 was addressed by Dr. Kelly Hale, Wilmington, on "Pelvic Appendicitis". At the business meeting, the following officers were elected: President, Dr. A. S. Stemler, Washington C. H.; vice president, Dr. Paul Craig, Washington C. H.; secretary-treasurer, Dr. James F. Wilson, Washington C. H.; legislative committeeman, Dr. R. M. Hughey, Washington C. H., medical defense committeeman, Dr. A. D. Woodmansee Washington C. H.; delegate, Dr. E. F. Todhunter, Washington C. H., alternate, Dr. Lucy W. Pine, Washington C. H. A committee was appointed to confer with the county relief director regarding medical relief for the unemployed. A

poll of the members showed a majority in favor of quarterly instead of monthly meetings.

Second District

Greene County Medical Society elected the following officers at its annual meeting December 7 at Xenia: President, Dr. C. E. Ream, Bowersville; vice president, Dr. George Davis, Xenia; secretary-treasurer, Dr. Harold Ray, Xenia; delegate, Dr. L. L. Taylor, Yellow Springs; alternate, Dr. H. C. Schick, Xenia; censor, Dr. A. C. Messenger, Xenia. The scientific program consisted of an address by Dr. H. W. Koerper, Columbus, on "Eclampsia".—H. C. Schick, M.D., retiring secretary.

Miami County Medical Society, in session December 1 at the Memorial Hospital, Troy, elected Dr. W. W. Trostel, Piqua, president for 1934, and the following other officers: Vice president, Dr. E. G. Puterbaugh, Tippecanoe City; secretary-treasurer, Dr. G. A. Woodhouse, Pleasant Hill; legislative and medical defense committeeman, Dr. E. A. Yates, Piqua; delegate, Dr. Foster Kiser, Tippecanoe City; alternate, Dr. B. M. Hogle, Troy.——Bulletin.

Montgomery County Medical Society was addressed by Dr. Walter Freeman, Washington, D. C., at its meeting December 1, on "Psychological Plagues—A Parable". At the business session, the society voted to charge interest on all accounts over six months delinquent.

On December 12, the society held a special meeting for the purpose of discussing medical examinations given by physicians to applicants for barbering licenses and medical aspects of the Civil Works Program.——Bulletin.

Preble County Medical Society in session November 15 elected the following officers for 1934: President, Dr. J. B. Lucas, West Alexandria; vice president, Dr. J. A. Carter, New Paris; secretary-treasurer, Dr. C. E. McKinley, Camden; legislative committeeman, Dr. J. C. Ryder, Eaton; medical defense committeeman, Dr. A. C. Hunter, West Alexandria; delegate, Dr. C. E. Newbold, Eaton; alternate, Dr. J. I. Nisbet, Eaton, alternate. Problems of medical relief to the unemployed were discussed at the business session.—C. J. Brian, Eaton, M.D., retiring secretary.

Shelby County Medical Society elected the following officers for the ensuing year at its meeting December 1, at Sidney: President, Dr, A. R. Edwards, Sidney; vice president, Dr. B. A. Welch, Sidney; secretary-treasurer, Dr. S. C. Yinger, Sidney; delegate Dr. V. W. LeMaster, Sidney; alternate, Dr. Welch.—S. C. Yinger, M.D., secretary.

Third District

Allen County—The Academy of Medicine of Lima and Allen County was addressed on November 21 by Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council of the American Medical Association, on "The Practice of Medicine —A Trade or Profession".—News clipping.

Hancock County Medical Society met on December 7 at the Elks' Club, Findlay. At the business session, the following officers for the ensuing year were elected: President, Dr. J. H. Marshall, Findlay; vice president, Dr. M. Hanna, Findlay; secretary, Dr. H. O. Crosby, Findlay; treasurer, Dr. E. J. Thomas, Findlay; legislative committeeman, Dr. H. R. Wynn, Findlay; medical defense committeeman, Dr. D. B. Biggs, Findlay; delegate, Dr. J. M. Firmin; alternate, Dr. J. V. Hartman. Dr. Rosella Biedermann, Jenera, was admitted to membership. Following the business session, Dr. F. M. Wiseley presented an illustrated lecture on "The Heart".—H. O. Crosby, M.D., secretary.

Hardin County Medical Society was addressed by Professor C. W. Pettit, Ada, of the law faculty at Ohio Northern University, at its meeting on November 23 at Kenton. Professor Pettit spoke on "Some Aspects of the Relation of the Medical and Legal Professions".—News clipping.

Marion County—New officers of the Academy of Medicine of Marion, elected on December 5 are: President, Dr. H. K. Mouser, Marion; vice president, Dr. D. B. Osborn, Waldo; secretary, Dr. J. W. Jolley, Marion; treasurer, Dr. Floyd Yeager, Marion; legislative committeeman, Dr. C. J. Altmaier, Marion; delegate, Dr. E. L. Brady, Marion; alternate, Dr. R. T. Morgan, Marion.—J. W. Jolley M.D., secretary.

Seneca County Medical Society held its annual election of officers on November 16 at the Shawhan Hotel, Tiffin. Those elected were: President, Dr. Paul J. Leahy, Tiffin; vice president, Dr. George W. Williard, Tiffin; secretary-treasurer, Dr. R. E. Hershberger, Tiffin; legislative committeeman, Dr. J. J. Heaton, Tiffin; medical defense committeeman, Dr. R. R. Hendershott, Tiffin; delegate, Dr. Hendershott; alternate, Dr. R. C. Chamberlin, Tiffin.—R. E. Hershberger, M.D., secretary.

Wyandot County Medical Society elected the following officers for 1934 at its regular meeting on December 7 at Upper Sandusky: President, Dr. B. A. Moloney, Upper Sandusky; vice president, Dr. C. W. Montgomery, Sycamore; secretary-treasurer, Dr. W. L. Naus, Upper Sandusky; legislative committeeman, Dr. Allen L. Walton, Upper Sandusky; medical defense committeeman, Dr. Frederick Kenan, Upper Sandusky; delegate, Dr. J. Craig Bowman, Upper Sandusky.—W. L. Naus, M.D., secretary.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

December 1—General session. Program: "Pelvic Infections", Dr. Norman F. Miller, professor of

obstetrics and gynecology, University of Michigan.

December 8—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Oxygen Therapy", Dr. K. C. McCarthy; "Special Anesthesia—Its Indications With Special Reference", Dr. A. A. Brindley.

December 15 — Medical Section. Program: "Chronic Non-Tuberculosis Infections of the Lung", Dr. Howard Holmes; discussants, Dr. Paul Holmes, Dr. E. G. Galbraith and Dr. W. W. Stone.

Four County Medical Society composed of physicians of Fulton, Defiance, Williams and Henry counties met November 9 at Wauseon. The program was conducted by Dr. L. A. Levison and Dr. C. A. Applebaum, both of Toledo.—News clipping.

Defiance County Medical Society elected the following officers at its meeting on December 12 at Defiance: President, Dr. John U. Fauster, Defiance; vice president, Dr. P. B. Newcomb, Defiance; secretary-treasurer, Dr. D. J. Slosser, Defiance; legislative and medical defense committeeman, Dr. S. E. DeMuth, Hicksville; delegate, Dr Slosser; alternate, Dr. Newcomb. After the business session, Dr. Newcomb presented a paper on "Paralytic Bowel Obstruction", and Dr. J. U. Fauster, Jr., presented a case report on "Congenital Stenosis of the Bowel".—D. J. Slosser, M.D., secretary.

Fulton County Medical Society at its annual meeting December 7 elected Dr. C. F. Hartmann, Wauseon, president for the ensuing year. Other officers elected were: Vice president, Dr. A. M. Wilkins, Delta; secretary-treasurer, Dr. George McGuffin, Pettisville; correspondent, Dr. W. H. Maddox, Wauseon; medical defense committeeman, Dr. C. E. Patterson, Fayette; legislative committeeman, Dr. C. L. Hutchins, Delta; delegate, Dr. R. W. Reynolds, Fayette; alternate, Dr. E. A. Murbach, Archbold.—Bulletin.

Putnam County Medical Society held its annual election of officers on December 5. Those elected were: President, Dr. W. D. Hickey, Leipsic; vice president, Dr. W. B. Recker, Leipsic; secretary-treasurer, Dr. W. B. Light, Ottawa; correspondent, Dr. A. L. Fipp, Glandorf; legislative committeemen, Drs. H. N. Trumbull, Columbus Grove, chairman, C. O. Beardsley, Ottawa, and C. W. Bird, Continental; medical defense committeemen, Drs. R. D. Bixel, chairman, Pandora, L. M. Piatt, Ottawa, and B. P. Davis, Fort Jennings; delegate, Dr. E. Blackburn, Kalida; alternate, Dr. B. E. Waterson, Continental.—W. B. Light, M.D., secretary.

Williams County Medical Society at its annual meeting elected the following officers for 1934: President, Dr. E. A. Snyder, Bryan; vice president, Dr. E. R. Jacka, Pioneer; secretary-treasurer, Dr. H. R. Mayberry, Bryan; delegate, Dr. W. A. Held, West Unity; alternate, Dr. H. W. Wertz, Montpelier. The society voted to withdraw from the Four County Society.——H. R. Mayberry, M.D., secretary.

Wood County Medical Society in session November 16 at Bowling Green was addressed by Dr. J. A. Muenzer, Toledo, on "Disturbances of the Edocrine System".—News clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

December 1—Clinical and Pathological Section. Annual "Intern Night" program consisting of the reading of the four prize winning manuscripts by the authors and final awards.

December 8—Experimental Medicine Section. Program: "A Preliminary Report on a Chemical Test for Sex Hormones Associated with Pregnancy", J. Paul Visscher, Ph.D. and Donald Bowman, B.A.; "Observations on Biological Tests for Pregnancy", Dr. J. T. Smith; "Hypo- and Hyperpituitarism", Dr. Anna Young; "The Pre-partum Determination of Sex", Dr. H. Goldblatt; "Further Studies Concerning Testicular Function", Dr R. R. McCullagh.

December 6—Pediatric Section. Program: "Kernicterus", Dr. G. Hacker; "Tacchycardia in Young Children", Dr. O. L. Goehle; "Gigantism", Dr. C. W. Burhans; "Heprosis", Dr. H. Kobes; "Diphtheria with Cardiac Complications", Dr. M. W. Martin; "Acute Encephalitis", Dr. J. A. Toomey; "Ruptured Retropharyngeal Abscess with Extension of Air and Pus into Mediastinum", Dr. E. Freedman; "Cretinism with High Blood Cholesterol", Dr. J. D. Pilcher.

December 13—Practice of Medicine Section. Program: "Cysts and Cyst-like Structures in the Chest (Congenital and Acquired)", Dr. Eugene Freedman; "Some Clinical Considerations of Venous Thrombosis", Dr. William H. Bunn, Youngstown; "A Case of Silico-Anthrocosis with Multiple Cavitation", Dr. Herman Shube.

December 14—Ophthalmological and Oto-Laryngological Section. Program: "Choice of An Anesthetic in Eye, Ear, Nose and Throat Surgery", Dr. F. W. Dixon; "Choice of Anesthetic in Eye Surgery", Dr. U. D. Seidel, Akron; "Is Swimming a Safe Form of Exercise? Report of Serious and Fatal Cases of Sinus Infection Following Swimming", Dr. W. B. Chamberlin.

December 15—General session. Program: "The Lure of Old Medical Books", Dr. Logan Clendening, Kansas City, Missouri, clinical professor of medicine at the University of Kansas.

December 20—Industrial Medicine and Orthopedic Section. Program: "The Incidence and Dis-

ability of Fractures in Certain Industries", Dr. A. L. Brooks; "Eye Injuries", Dr. Paul G. Moore; "Medico-Legal Hazards", Dr. H. H. Drysdale.

Ashtabula County Medical Society held a dinner meeting December 12 at Conneaut and elected the following officers for the ensuing year: President, Dr. J. F. Docherty, Conneaut; vice president, Dr. E. H. Merrell, Geneva; secretary-treasurer, Dr. A. M. Mills, Ashtabula; legislative and medical defense committeeman, Dr. R. B. Wynkoop, Ashtabula; delegate, Dr. Wynkoop; alternate, Dr. P. J. Collander, Ashtabula. Following the business session, the society was addressed by Dr. Arthur G. Davis, Erie, Pa., on "Treatment of Fractures of the Vertebrae and Various Open Reduction Operations Involving the Heel, Forearm, Tibia and Hip".

On November 16, the society was addressed by Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, on "Differential Diagnosis of Certain Types of Anemia".—A. M. Mills, M.D., secretary.

Erie County Medical Society was addressed on November 23 by Dr. Verne A. Dodd, Columbus, and Dr. G. F. Thompson, chief surgeon of the Sandusky Soldiers' Home.——News clipping.

Geauga County Medical Society has elected officers for the ensuing year as follows: President, Dr. Lura E. Gordon, Burton; vice president, Dr. F. S. Basquin, Chardon; secretary-treasurer, Dr. Isa Teed-Cramton, Burton; legislative committeeman, Dr. Walter C. Corey, Chardon; medical defense committeeman, Dr. C. F. Gilmore, Chardon.—Isa Teed-Cramton, M.D., secretary.

Huron County Medical Society met November 15 at the Willard Municipal Hospital. The guest speaker was Dr. Jonathan Forman, Columbus, who discussed "Hay Fever, Asthma and Other Allergic Diseases". At the business session, the following officers were elected: President, Dr. H. H. Ewing, Willard; secretary-treasurer, Dr. J. C. Steiner, Willard; legislative committeeman, Dr. George F. Linn, Norwalk. Dr. Harold Bolman was elected to membership. A fish fry was held following the meeting.—News clipping.

Medina County Medical Society at its meeting November 16 at Medina, elected the following officers: President, Dr. Harry Streett, Litchfield; secretary-treasurer, Dr. James K. Durling, Wadsworth; legislative committeeman and delegate, Dr. E. L. Crum, Lodi. The guest speaker was Dr. G. A. Palmer, Akron, who discussed "Use and Abuse of Forceps in Obstetrics".—News clipping.

Sixth District

Ashland County Medical Society elected officers for the ensuing year at its meeting November 10 as follows: President, Dr. O. J. Powell, Ashland; vice president, Dr. L. G. Sheets, Ashland; secretary-treasurer, Dr. M. J. Thomas, Jeromeville; legislative committeeman, Dr. Thomas; medical defense committeeman, Dr. C. C. Patton, Ashland; delegate, Dr. George Reibel, Ashland; alternate, Dr. Paul E. Kellogg, Ashland. An economic committee composed of Drs. W. F. Emery, L. G. Sheets, H. M. Gunn, George Reibel and E. L. Clem was appointed to confer with county officials relative to medical service for the needy unemployed. The guest speaker was Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council of the American Medical Association, who discussed economic, social and professional questions.

At its meeting on November 24, the society was addressed by Dr. Donald Ralston, McConnelsville, on "Tuberculosis in Childhood".—Paul E. Kellogg, M.D., retiring secretary.

Portage County Medical Society met in regular session December 7. At the business session, the following officers were elected: President, Dr. Edgar H. Knowlton, Mantua; vice president, Dr. Ivor Campbell, Mogadore; secretary-treasurer, Dr. E. J. Widdecombe, Kent; legislative committeeman, Dr. George J. Waggoner, Ravenna; medical defense committeeman, Dr. W. B. Andrews, Kent. Following the business session, an address on "Some Common Skin Diseases" was made by Dr. C. G. LaRocco, Cleveland.—E. J. Widdecombe, M.D., secretary.

Stark County Medical Society met at the Elks' Club, Canton, on December 12 with Dr. Paul A. O'Leary, Rochester, Minn., as guest speaker. Dr. O'Leary spoke on "Therapeutic Problems of Syphilis". Refreshments were served following the program.—Bulletin.

Seventh District

Belmont County Medical Society met on December 7 and elected officers as follows: President, Dr. Charles H. Cale, Neffs; president-elect, Dr. W. L. Davis, Martins Ferry; secretary-treasurer, Dr. C. W. Kirkland, Bellaire; legislative committeeman, Dr. R. H. Wilson, Martins Ferry; censor, Dr. J. O. Howells, Bridgeport; delegate, Dr. Kirkland; alternate, Dr. C. V. Porterfield, St. Clairsville; correspondent, Dr. F. R. Dew.—F. R. Dew, M.D., correspondent.

Columbiana County Medical Society at its meeting on December 12 elected Dr. Seward Harris, Lisbon, as president for the ensuing year. Other officers elected were: Vice president, Dr. J. M. King, Wellsville; secretary-treasurer, Dr. Guy E. Byers, Salem; legislative committeemen, Dr. J. P. Sharp, Salem, and Dr. M. D. McCutcheon, East Liverpool; medical defense committeeman, Dr. C. R. Larkins, East Liverpool; delegate, Dr. P. H. Beaver, Leetonia; alternate, Dr. J. M. King, Wellsville.—John A. Fraser, M.D., retiring secretary.

Coshocton County Medical Society was addressed by Dr. J. D. Lower, Coshocton, on "Treat-

ment of Pneumonia" at its regular meeting November 23.—News clipping.

Eighth District

Athens County Medical Society has elected the following officers for the year 1934: President, Dr. C. H. Creed, Athens; vice president, Dr. W. E. Howe, Nelsonville; secretary-treasurer, Dr. T. A. Copeland, Athens; censor, Dr. A. J. Pritchard, Nelsonville; delegate, Dr. C. S. McDougall, Athens.—T. A. Copeland, M.D., secretary.

Fairfield County Medical Society held a luncheon meeting November 27 at the Crystal Springs Inn, complimenting Dr. R. W. Mondhank who is convalescing from an extended illness. Informal talks made up the program.—News clipping.

Guernsey County Medical Society held a short business meeting November 16 at the Romance Restaurant, Cambridge. There was no program so the meeting was devoted to a discussion of organization activities.—News clipping.

Licking County Medical Society was addressed on November 24 by Dr. R. E. Bushong, superintendent of the State Hospital for the Criminal Insane, Lima. Dinner was served preceding the program.—News clipping.

Morgan County Medical Society held its annual meeting December 12 at the Hotel Kennebec, McConnelsville. The following officers were elected: President, Dr. Donald G. Ralston, McConnelsville; vice president, Dr. Lee Humphrey, Malta; secretary-treasurer, Dr. C. E. Northrup, McConnelsville; delegate, Dr. Galen Rex, McConnelsville; alternate, Dr. A. C. Whitaker, Chesterhill. It was voted to hold the next meeting of the society on January 16.—C. E. Northrup, M.D., secretary.

Washington County Medical Society in session December 13 at Marietta was addressed by Dr. Walter R. Griess and Dr. Robert C. Peale, both of Cincinnati. The subject discussed was "The Use of Avertin as An Anesthetic".—Bulletin.

Ninth District

Gallia County Medical Society met at The Holzer Hospital, December 8th, with a good visiting attendance from the adjoining counties of Jackson and Meigs. The program consisted of a dinner given by Dr. Holzer after which he presented four motion pictures on "Cancer of the Skin", supplied by The American Society for the Control of Cancer.—News Clipping.

Jackson County Medical Society at its regular meeting December 5, elected officers as follows: President, Dr. J. S. Hunter, Jackson; secretary-treasurer, Dr. J. J. McClung, Jackson; legislative committeeman, Dr. W. R. Evans, Jackson; medical defense committeeman, Dr. E. T. Dando, Wellston; delegate, Dr. A. G. Ray, Jackson; alternate, Dr. J. L. Frazer, Wellston.—J. J. McClung, M.D., secretary.

Lawrence County Medical Society elected Dr. Cosper Burton, Ironton, president of the society for the ensuing year at its regular meeting on December 7. Other officers elected were: Vice president, Dr. Vincent V. Smith, Ironton; secretary-treasurer, Dr. Anne D. Marting, Ironton; legislative committeeman, Dr. George G. Hunter, Ironton; medical defense committeeman, Dr. Forrest R. Stewart, Ironton; delegate, Dr. Smith; alternate, Dr. Ralph F. Massie, Ironton.—Anne D. Marting, M.D., secretary.

Pike County Medical Society has elected the following officers for the ensuing year: President, Dr. L. E. Wills, Waverly; vice president, Dr. P. H. Jones, Stockdale; secretary-treasurer, Dr. Robert T. Leever, Waverly; legislative committeeman, Dr. Leever; medical defense committeeman, Dr. I. P. Seiler, Piketon; delegate, Dr. Leever.—Robert T. Leever, M.D., secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Geo. J. Heer, M.D., Acting Secretary)

December 4—General session. Program: "Diverticulosis", (diagnosis) by Dr. E. H. Chapin, (pathology) by Dr. R. S. Fidler, and (*X*-ray) by Dr. H. V. Weirauk; discussion by Dr. Fred Fletcher and Dr. Wells Teachnor, Jr.

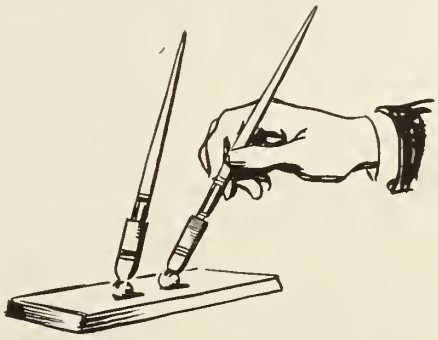
December 10—Memorial services at St. Joseph's Cathedral for the following physicians who died during the past year: Drs. Albert W. Dumm, Suzanne Long Bryant, John O. Hoffhine, Charles O. Probst, Joseph Dallas Smith, Ira Baird Hamblin, Schuyler O. Giffin, Clarence E. Romans, Anna Mary Dice, John H. Hanes, A. M. Bleile, Robert S. Drury, James W. Watts, J. M. Clemmer, Alfred C. Smith and Alfred Robinson.

December 11—General session. Program: "Progress in Surgery", Dr. W. B. Morrison; "Progress in Obstetrics", Dr. Roy Krigbaum. At the business session a report of the committee named to investigate the Franklin County Tuberculosis Sanatorium was presented by Dr. J. F. Baldwin and Dr. E. R. Shilling.

December 18—General Practitioners' Section. Dinner and business meeting.

Crawford County Medical Society was addressed by Dr. George F. Nelson, Columbus, at its regular meeting on December 4. Dr. Nelson spoke on "Cardio Vascular Disease". At the business session, the following officers for 1934 were elected: President, Dr. Russell J. Caton, Bucyrus; vice president, Dr. C. A. Adams, Galion; secretary-treasurer, Dr. J. A. Agnew, Crestline; correspondent, Dr. C. A. Lingenfelter, Bucyrus; legislative committeeman, Dr. W. G. Carlisle, Bucyrus; medical defense committeeman, Dr. M. L. Helfrich, Galion; delegate, Dr. D. G. Arnold, Bucyrus; alternate, Dr. R. L. Solt, Bucyrus.—R. L. Solt, M.D., retiring secretary.

Delaware County Medical Society has elected



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Morrow County Medical Society in session December 6 elected the following officers for 1934: President, Dr. C. E. Sherman, Cardington; vice president, Dr. F. E. Thompson, Marengo; secretary, Dr. T. Caris, Mt. Gilead; treasurer, Dr. R. L. Pierce, Mt. Gilead; legislative committeeman, Dr. Pierce; medical defense committeeman, Dr. F. Sweeney, Mt. Gilead; delegate, Dr. F. M. Hartsook, Cardington; alternate, Dr. Caris.—T. Caris, M.D., secretary.

Union County Medical Society met at Raymond on November 14 as the guest of Dr. C. A. Thompson. Following a dinner, public health and public welfare questions were discussed. The society voted to launch an immunization program whereby physicians would endeavor to have parents have their children immunized and vaccinated by the family physician during the first six months of the child's life. It was pointed out that the plan undoubtedly would meet with the approval and commendation of the county board of health.

On December 1, the society held its annual meeting and elected the following officers for the ensuing year: President, Dr. H. C. Duke, Richwood; vice president, Dr. P. D. Longbrake, Marysville; secretary-treasurer, Dr. Angus MacIvor, Marysville; correspondent, Dr. J. D. Boylan, Milford Center; legislative committeeman, Dr. F. C. Callaway, Marysville; medical defense committeeman, Dr. C. D. Mills, Marysville; delegate, Dr. Boylan; alternate, Dr. Callaway.—J. D. Boylan, M.D., correspondent.

NEWS NOTES of OHIO

Columbus—Dr. John B. Alcorn has been elected chairman of the staff of St. Francis Hospital, and Dr. Aaron S. Canowitz, secretary.

Dayton—Dr. Myron Metzenbaum, Cleveland, was the guest speaker at a dinner meeting on December 12 of the Dayton Oto-Laryngological and Ophthalmological Society at the Van Cleve Hotel. He discussed "Reconstructive Surgery of the Eyelids, Cleft Palate and Nasal Surgery". On the afternoon of that day, Dr. Metzenbaum held a diagnostic and surgical clinic at St. Elizabeth Hospital on "Recent and Old Nasal Fractures in Children".

Wauseon—The first of a new series of clinical lectures to be given at the Detwiler Memorial Hospital, here, financed by the Commonwealth Fund, was given on November 23 by Dr. Norman F. Miller, professor of obstetrics and gynecology, University of Michigan. His subject was "Bleeding in the Last Trimester of Pregnancy".

Chardon—Dr. Lucy Hertzog suffered severe injuries in an automobile accident.

Lebanon—Announcement has been made of the marriage of Miss Helen Craig, Longview, Washington, and Dr. J. F. Smyth, who recently moved to Lebanon from Toledo, the son of Dr. and Mrs. Thomas F. Smyth, Lyons.

Grove City—Dr. J. C. Sommer was badly injured when his automobile skidded into the ditch.

Oak Harbor—Dr. David P. Young, until recently connected with the Veterans' Administration, Washington, has opened an office here for private practice.

Xenia—Dr. W. D. Haines, Cincinnati, addressed the Xenia Kiwanis Club on "Civilization of America".

Findlay—Dr. H. O.Crosby has resumed practice after serving six months in the medical corps at conservation camps in Kentucky.

Hepburn—Dr. J. H. Holcomb, Hardin County coroner, was injured in an automobile accident near here.

Minister—Dr. T. H. Will, formerly of Coldwater, has opened an office here.

Cincinnati—A Physicians Business Bureau to assist members in collecting accounts and establishing credit ratings for patients, has been opened by the Cincinnati Academy of Medicine.

Cambridge—Dr. Fred W. Lane has recovered from injuries sustained in a fall and has resumed active practice.

Xenia—Dr. Ben R. McClellan and Mrs. McClellan were injured when their automobile skidded on the ice into a ditch near New Vienna.

Marysville—Dr. H. E. Stricker, formerly of Bucyrus, has opened offices here.

Delaware—Dr. W. E. Borden has returned from Moga, India, where he devoted two months' study in an eye clinic.

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PUBLIC HEALTH NOTES

—Up to December 15, 20 cases of amoebic dysentery in Ohio had been reported to the State Department of Health. Health commissioners and physicians have been requested by the State Department of Health to exert every effort to see that all known cases are reported so that a careful check may be had on the course of the disease in Ohio. Dr. H. G. Southard, state director of health, has issued the following statement regarding the disease:

"Amoebic dysentery is a much more serious infection than ordinary dysentery and frequently causes death from exhaustion, intestinal hemorrhage, perforation, or liver abscess.

"The great majority of cases run a chronic course with frequent intermissions and relapses that may occur after an interval of weeks, months or years and a serious or fatal complication may arise during any period of the infection.

"The onset is generally insidious; there may be more or less complaint of diarrheal symptoms, and quite often a perforatiton of the intestinal wall, leading to a fatal peritonitis, may occur in a patient who, judged by clinical symptoms, would not be considered as suffering from anything serious.

"Persons who have visited Chicago are advised that, should they develop diarrheal symptoms, safety demands that a physician be consulted in order that a microscopical examination of stools may be made at once and further that a check-up may be made on similar cases by the local health department.

"Local health departments should inform the State Department of Health at once of cases found in their districts."

—The new, one-shot toxoid for diphtherial immunization is now being used in various sections of the state, according to Dr. Finlay Van Orsdall, chief of the division of communicable diseases, State Department of Health. Dr. Van Orsdall has advised physicians not to be disturbed over the appearance of lumps and swelling at the point of injection of the new serum since this condititon is a natural reaction to the one-shot toxoid which contains alum and does not disseminate as rapidly as the two-shot and three-shot serums, but produces greater immunization.

—Dr. F. R. Stamp, Alliance, has been appointed health commissioner of Stark County.

—Dr. John L. Maurer, West Liberty, has been appointed a member of the Logan County Board of Health, succeeding Dr. Lee Traul, Middleburg, resigned, who was named health commissioner of the county.

—Dr. James F. Wilson, health commissioner of Fayette County, addressed the Washington C. H. Rotary Club on "Your Child, Your Greatest Asset".

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BALTIMORE, MARYLAND

—In a recent issue of the *Ohio Health News*, there appeared the following discussion of trench mouth which has been prevalent in Ohio, almost in epidemic form, during the past year:

"This is a specific infection due to a *fusiform bacillus* and an accompanying *spirillum* resembling morphologically, the *spirochete*. The infection has a wide geographical distribution, as it is very prevalent in India, Japan and other far eastern countries and is endemic all over Europe and North America.

"While infection may occur on any mucous membrane, it is more frequent in the mouth and throat, more especially on the edges of the gums and on the tonsils, and it may extend to the soft palate, the *buccal mucosa* and the tongue.

"Lesions on the tonsils are usually unilateral and appear first as sloughing patches, varying in size from half a centimeter to patches involving the entire tonsil. These patches are easily removed, leaving a bleeding area which rapidly again becomes covered. The ulceration that occurs under this grayish-white or yellowish membrane deepens, but usually does not extend laterally beyond its limits.

"During the progress of infection there is quite frequently glandular involvement, some rise in temperature, although constitutional symptoms are slight, and, as a rule, a characteristic fetid odor is present.

"The infection has been known as a more or less endemic disease since about 1897, but it was not until the World War broke that it took an epidemic form among the soldiers in France and became known as 'trench mouth'. Its true nature was soon recognized, but owning to the conditions under which the troops were forced to live little could be done to check its spread.

"It was found that the milder, more common form did not affect the tissues deeply and that the true, ulcerative variety was usually found in unclean mouths where decayed teeth were present, around areas where faulty dental work over-hung gum margins and became irritants, or where the soft tissues of the mouth had received injury or were already affected by some other infection, such as pyorrhea.

"The exact mode of transmission has not been entirely agreed upon, but there is little doubt that it is spread by more or less direct contact—eating utensils not properly cleaned, face towels, drinking cups, kissing, living in crowded quarters without plenty of fresh air and sunshine, are some of the causes."

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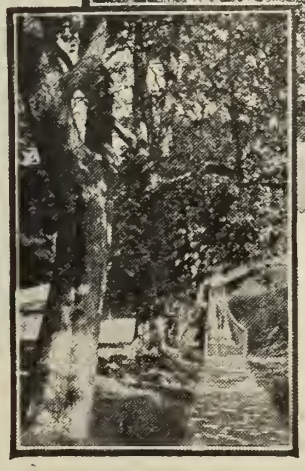
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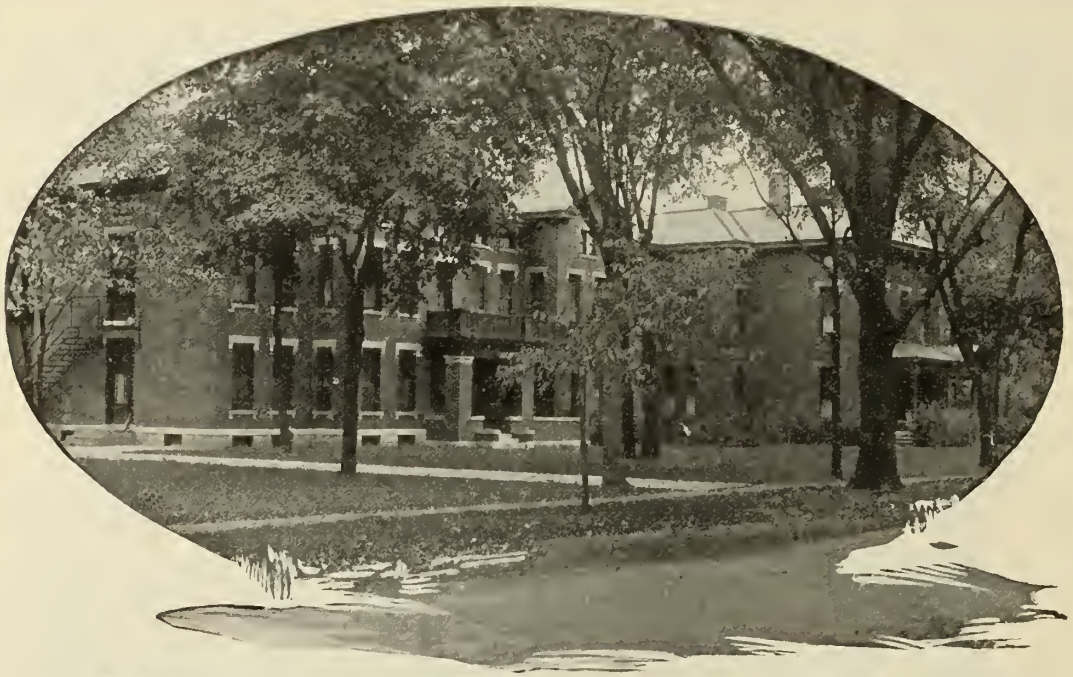




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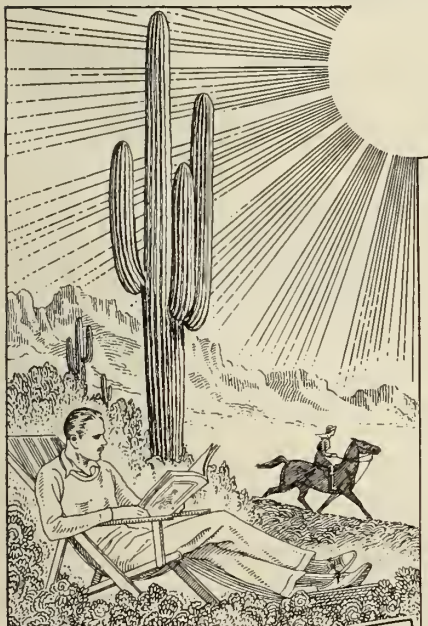
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CLIMATOLOGICAL DATA
(Compiled from U. S. Weather Bureau Reports)

	Jan.	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct.	Nov	Dec	
TEMPERATURE (Mean monthly—40-year average)	49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8	Total 11.57
RAINFALL (In Inches—40-year average)	.8	.96	.81	.32	.14	.23	2.4	2.46	1.0	.6	.76	1.09	Aver. 49.5
HUMIDITY Monthly (40-year average) A. M.	61	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.3	46.8	57.1	74.2	
HUMIDITY Monthly (40-year average) P. M.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1	48.1	29.9

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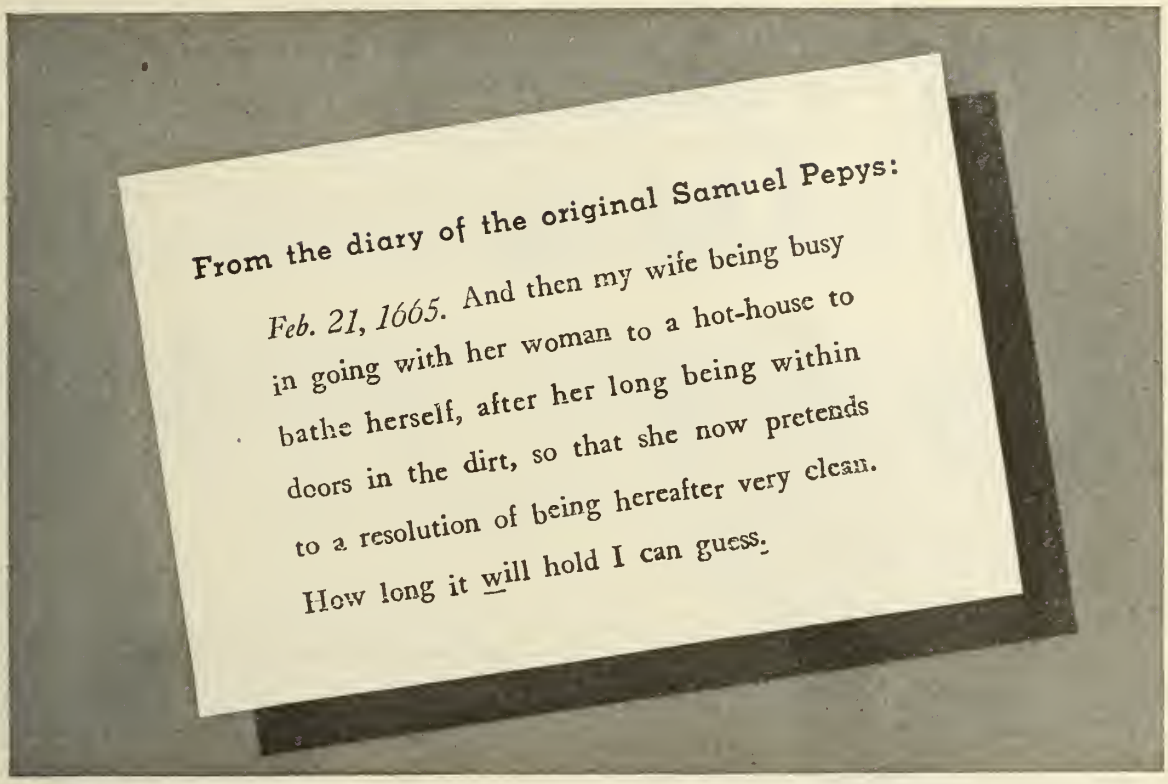
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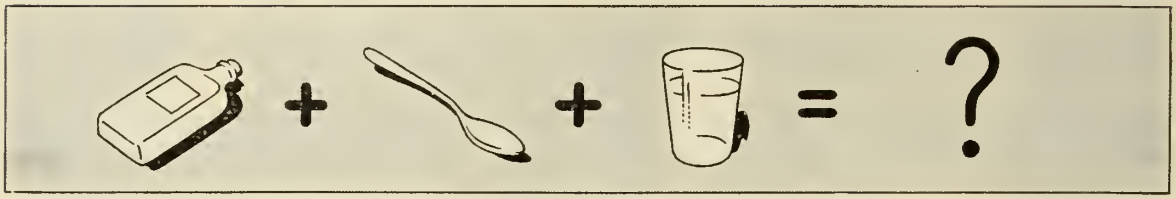
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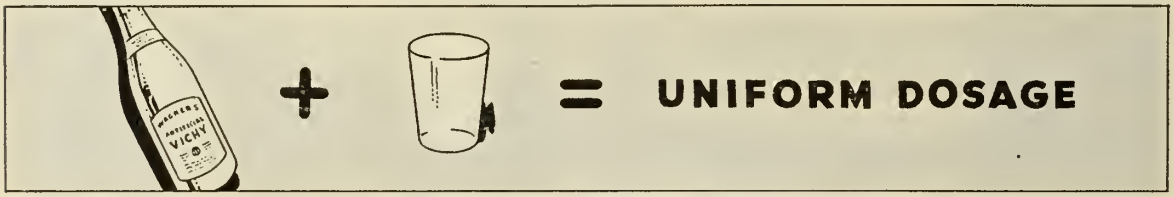
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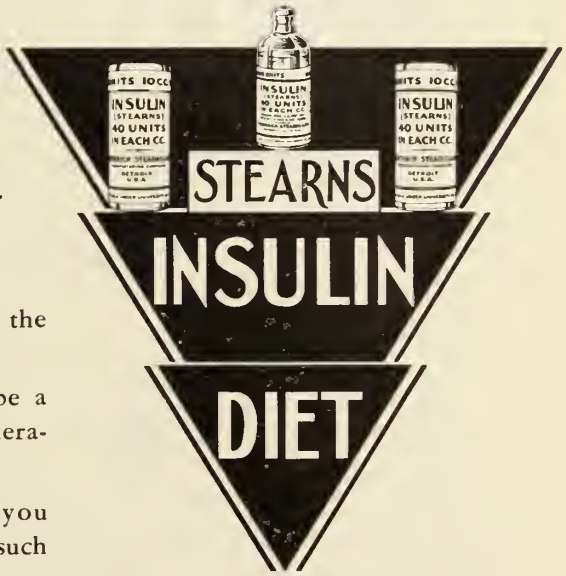
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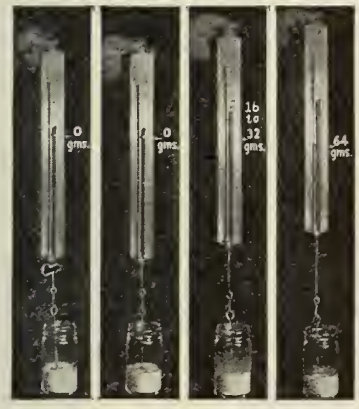
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[1] Morse and Talbott, Diseases of Nutrition and Infant Feeding, pgs. 214, 215.

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

In view of rapid changes and extensive experimentation taking place in economic, social and political structures, it is timely and of utmost importance that the medical profession as a group give its serious consideration to some of the major social and governmental tendencies which are having an immediate and far-reaching effect on physicians as a professional group and, in fact, on the entire system of medical practice

Medicine in The Social Revolution

Students of social and political history have observed that society today is in the midst of a social revolution; a period of experimentation in collectivism and other social theories unequalled in its significance in the history of the world.

The medical profession should frankly recognize that considerable sentiment has been crystallized for the absolute socialization of medicine as a part of the social experiment for centralization and extension of the Federal government's functions; either through legislation or by governmental manifesto, or both.

No less an authority than Dr. W. C. Rappleye, former director of study of the National Commission on Medical Education and present dean of the College of Physicians and Surgeons, Columbia University, in his recent annual report to the officials of that institution, declared:

"The far-reaching concepts of collective responsibility now modifying our entire social and economic structure are bound to have influences which will vitally affect the physician as an individual, the medical profession as an organization and the relationships which have previously existed in the care and treatment of the sick. In the confusion which necessarily accompanies broad changes of this character, the widest range of suggestions are made to deal with the problems.

"The encouragement and influence given to collective bargaining and the marked extension of the voice of the goverment in the conduct of national affairs may bring about sweeping changes in the methods of providing medical care for the public.

"Probably it is too early to obtain a clear indication of the direction and extent to which these changes may modify the earlier order of things, but there is every reason to assume that these changes in public thinking and collective action will sooner or later influence the forms of medical care of the people.

"The growth of collective planning in regard to wages, hours of employment and living conditions is likely to produce the organization of groups for the mass purchase of medical and other services. The long period of economic stress has exhausted the resources of large numbers of the population, who are becoming dependent upon government aid and public institutions."

This observation from one who is a recognized and well-informed authority on social, economic and governmental trends affecting medicine is but one of numerous bits of evidence of the seething undercurrents toward the establishment of programs and systems radically changing the traditional and normal relationships between physician and patient.

Under the heading "Health Insurance Gains Impetus", the American Association for Social Security, Inc., in a recent bulletin, said:

"The most significant development in the movement for health insurance this year has been the publication of the extensive reports of the Committee on the Costs of Medical Care. While the unwieldly large Committee was divided on many of its recommendations, the exhaustive studies of its investigators all pointed to the present anomalies of existing health provisions. Thousands of doctors sit idly by waiting for patients while nearly half of the individuals studied by the Committee in the lowest income groups received no professional medical or dental attention of any kind.

"These revelations have given considerable impetus to the movement for compulsory health insurance. Bills for health insurance have been introduced in a number of states, notably Pennsylvania and Wisconsin. Bills for comprehensive systems of social insurance introduced in several states also contained provisions for compulsory health insurance. The Association plans to hold in the near future a conference of experts for the purpose of drafting a model health insurance bill for presentation to the 1934 legislatures."

Summaries of the progress of social legislation, both state and national, during the past year indicate the changing conception in the public mind toward government and the growing sentiment in favor of governmental supervision and regulation of activities which have heretofore been left to private initiative and enterprise.

Brief mention is made to these matters merely to emphasize to the medical profession that it, together with numerous other groups of society, is in the midst of the most critical period in its history. The situation demands careful study, calm deliberation, seasoned judgment, and aggressiveness on the part of the medical profession through medical organization.

Our whole social system is in the course of transition. Nothing in the present scheme of things

is permanently fixed. Problems affecting medical practice are numerous, many of them varying in scope and importance in accord with local conditions and local viewpoints.

In fact, conditions and situations have been changing so rapidly that it would be practically impossible to devise definite plans or systems to apply to all sorts of varying local problems or in anticipation of future developments, even if this course were practicable.

Fundamental principles and policies which have the endorsement of medical organization do exist and are sufficiently clear in their intent to meet local problems and general enough in their scope to form the basis for any action which the medical profession of any community may see fit to take to preserve its rights and safeguard, as far as possible, the practice of medicine for the individual physician.

A fatal policy for medical organization to follow in the opinion of many medical leaders who have given careful study to present conditions, would be the adoption of rigid plans, based on a theory of isolated action and without regard for or understanding of social tendencies and public demands.

Moreover, medical organization should avoid so far as possible prejudicing itself in future negotiations by a stand, a position or a plan which in retrospect may be found to be ill-considered action, taken in the stress of circumstance; out of tune with changing social factors, and which would set a precedent from whose implications the profession could not escape.

The most effective way to meet many of the problems which confront the medical profession is not clear. However, one thing is definite and should be borne in mind by every physician. That is, nothing can or will be gained by the profession in dealing with questions which have already arisen and those that will arise in the future unless it "act as a united profession and not as a collection of units". To assure this united activity, strong, harmonious and aggressive medical organization must be maintained, by which and through which only, the integrity of scientific medicine can be preserved and a valiant fight made to keep as a basis for medical practice of the future the fundamental policies and principles that have made medicine the vital factor in civilization that it is today.

Viewpoints On Public Relations

Not long ago in addressing the Tennessee State Medical Association, Dr. Dean Lewis, president of the American Medical Association, quotes from a conversation he had with Former Governor Alfred E. Smith of New York to illustrate a point which sparkles with common, everyday horse sense.

Dr. Lewis recalled that during his conversation with Smith he referred to the current agitation over costs of medical care and the various questionable proposals which have been advanced by various groups for changing the present form of distribution of medical services, to which the former governor replied:

"Lewis, are you absolutely sure you aren't going to put them on the map by talking about them? I have found that there is a definite time to talk and there is a definite time to keep still. You want to be absolutely sure in arguing with these people and keeping it before the public all the time that you aren't going to put them on the map."

As Dr. Lewis concluded: "There is something in that; we don't want to make martyrs of them".

Obviously, the medical profession weakens its own position in the public's estimation by engaging in open assaults and public controversies with those who have undertaken to reform medical practice along radical lines.

It is essential that the medical profession within its own ranks study and discuss fully and frankly every proposal which affects in any way the practice of medicine and the health of the public. It is vital that the profession formulate plans, constructive in nature and which in the end will prove beneficial to the public generally. On the other hand, it may be prejudicial for physicans as individuals or through organization to glorify their self-appointed critics through public debate or public denouncement.

A real problem confronting the medical profession is to maintain the confidence which the public has in the accomplishments of medicine under practical forms of medical practice, by keeping medical practice on the highest possible plane and by improving the relationship between the public and the physician so that the former will have a better understanding of the physician's problems and what he has accomplished and is continually doing in the interests of humanity.

Many may find it easy to agree with the views of Dr. Thurman B. Rice, Indianapolis, on this question of public relations and popular medical education. Speaking before the Indianapolis Medical Society, Dr. Rice referred to the strained relationship which has arisen between the medical profession and a part of the population, stimulated by groups of laymen who feel that the welfare of the public demands that they take the control of medical affairs out of the hands of the physician. Then, he went on to declare:

"We are largely responsible for this state of affairs. We have not taken the public along with us. In spite of the fact that it is they who pay the bills; it is their health which is concerned; it is their bodies on which we operate; it is their wives, husbands, children, their fathers and mothers, their brothers and sisters and friends whose lives we are manipulating; we have sometimes taken the position that it was none of their business.

"Fifty years ago a physician drove a horse and buggy at a very low cost. He maintained a one-

room office; he had no telephone or office girl; he was not a member of half a dozen societies with high fees; the drugs he gave were chemical substances or vegetable products which were quite cheap; he needed no expensive equipment or instruments. When he came to the bedside he felt the pulse, looked at the tongue, inquired about the bowels, took the temperature, and made such an examination as his eyes, ears and fingers would permit. Under the circumstances, of course, his fee was small. Modern medicine, however, demands a far more elaborate set-up. The patient must pay for *X*-rays, blood examinations, metabolism tests and half a dozen other expensive things which are mighty important and worth while—but does the public know that they are important and worth while? That is the point. These matters are not merely of interest to us alone. The reasons for them need to be explained. It must be pointed out that whereas modern medical procedures cost much more they are also worth much more.

"We exist for the sake of the layman. There is no need that we point out every detail of the technique of a surgical operation to him, but he does have the right to know in a general way what our objective is and where we are going and why. He ought to know when to send for a doctor; he ought to have some criteria by which he may judge for which doctor he shall send. Having gotten the doctor, he should have such an understanding of diseases and such an appreciation of the functions and limitations of medical men that he will be able to give intelligent cooperation to the physician."

Present-day developments clearly indicate that the medical profession dare not imitate the ostrich. It must acquaint the public with its problems and counsel with it concerning some of these important questions.

However, as Dr. Lewis has said, it is highly important that the physician know when to talk and, as Dr. Rice has pointed out, what to say.

Concerning Prescriptions

The furore which has arisen from efforts now underway to tighten up Federal control of the marketing of food, drugs and cosmetics has brought out some interesting, as well as tragic, information concerning various ways being used to swindle the public and harm public health by unscrupulous producers and distributors of such products.

The medical profession is heartily in favor of having drastic regulations instituted in an effort to protect the public from frauds of this kind. It has said so on numerous occasions and has used its influence to bring about reforms in statutory regulation of the food, drug and cosmetc industries.

However, there is little the physician as an individual can do about the matter. Naturally, he can do little to prevent people from squandering their money on worthless patent medicines. Usually when he does blow a verbal blast at medical frauds and worthless concoctons, he is accused of prejudice and unfairness.

There is one thing, however, the physician can do to protect his patients and give them some assurance that they are not going to be gyped or be the victims of harmful products. That is in the matter of care and judgment in the writing of prescriptions.

The editor of the *Indiana State Medical Journal* in a recent issue of that publication stressed the point we have in mind in a concise and direct manner when he declared:

"It takes a physician a long time to acquire the knowledge which permits him the responsibility of writing a prescription. He puts on this piece of paper the authority for a licensed pharmacist to deliver to a patient drugs which are potentially dangerous or worthless if not correctly componded or directions not conscientiously followed. The physician's reputation is not infrequently carried in this slip of paper. It should be a specific order, and not one to be filled at the choosing of anyone else in any other way except as intended.

"It is to be assumed that the writer of the prescription understands explicitly the nature of the drugs for which he writes. This means that he knows the origin and preparation of the individual constituents of a prescription. All pharmaceutical houses do not prepare drugs in a like manner. Every tincture or fluid extract of a drug is not the same. Not all ergot or digitalis preparations are alike. Not every one-grain tablet of thyroid or one c.c. of pituitrin is equal in all respects to another put up by a different firm. Many firms make only a few preparations to which they give the most painstaking care. It is possible that they may have processes and qualifications superior to a firm making a complete line. Physicians soon become familiar with the nature of certain preparations and rely upon them. Undoubtedly many competing preparations do not give the expected results.

"With very little extra trouble when writing a prescription one can specify the preparation he specifically wishes, and he has every reason to expect that the specified preparation will be dispensed."

Through careless prescription writing, a physician can contribute much harm to his patients and indirectly prove himself an ally to the unscrupulous pharmacist or producer of inferior drugs. To protect his own reputation and safeguard the best interests of his patients, the physician should know what preparations are the most effective; should specify that only these be used in filling prescriptions, and should instruct his patients to have prescriptions filled only at pharmacies of known reputation for honesty and caution.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

A RECENT exhibition at the Academy of Medicine in Cleveland showed a surprising diversity in the hobbies of physicians. Some showed specimens of their own work in oil, pastels, and water colors, photography, wood carving, and furniture design, while others showed splendid collections they had gathered together of fine books, engravings, paintings, medical instruments, guns and pistols. The exhibit was of interest and value on account of the work displayed and of especial significance because it showed the desire men have for pursuits outside the boundaries of their daily work. The possible avocations are numerous, including music, out-door sports, and travel; many would not lend themselves to display in an exhibition of the sort. This applies to one hobby which we would commend to physicians looking for an outlet for their energies, and that is work in medical organizations, specifically, in the county medical societies. This furnishes a fascinating avocation and at the same time an opportunity for public service, often of the greatest value to one's profession.

I have in mind two secretaries who have devoted many years to unselfish work of this sort. Dr. William E. Hart of Elyria has been the secretary of the Lorain County Medical Society for so long that he has forgotten the time when he began, but it was more than twenty years ago. Under his watchful care, his society has grown to a membership of almost one hundred. He is responsible for splendid practical programs for the meetings which are held in rotation in the different cities and towns of his populous county. He stimulates the younger members, whom he calls "my boys", to prepare papers with resulting benefit to them. It is unnecessary for this society to import many speakers; its own programs are interesting and attractive. Dr. Hart serves as mentor, guide and friend, with broad knowledge based on years of experience, maintaining a compact organization, one which is able to cooperate efficiently at all times with the State Association of which it is a component part.

A similar service has been rendered by Dr. Isa Teed Cramton in Geauga County. This county contrasts sharply with Lorain, for it is rural, hilly, thinly populated, having only fifteen physicians. Often the roads between the towns are impassable in winter so that most of the meetings are held in the summer and there is lacking the stimulus which comes with a larger membership or with the constant additions of younger physicians who bring in fresh enthusiasm. Notwithstanding all this, Dr. Cramton, under the leadership of the late beloved Dr. Frank S. Pomeroy, kept persistently on the job for over twenty years, and as a result, the Geauga County Medical Society is well organized, interested, alert and harmonious, and stands out as one of the best of the smaller societies in our state association.

Dr. Hart and Dr. Cramton have been named because I am familiar with their achievements through my work as district councilor. There are others in this state of long experience and equally valuable service. I find that records in the headquarters office of our State Association show that 36 of the present secretaries or secretary-treasurers of component county societies have served five years or more; 17 of these have served 10 years or more, and six of them have served 15 years or more. Others who are former secretaries or secretary-treasurers have equally commendable and valuable records of service. There are many who have been secretaries for shorter times but who have succeeded in revitalizing apparently moribund societies, stimulating fresh interest, inaugurating new ideas in programs, inciting others to greater efforts. To all of these loyal secretares I wish to pay grateful and well-deserved tribute. They are truly the salt of the earth, and if all our 88 counties were so served, we would have in this state the best informed and most alert doctors possible, due to well planned and instructive programs; and from an organization standpoint, our association would have invincible strength because of continuity in experience.

This is, therefore, an earnest plea addressed to those looking for a hobby that they consider one close at hand, one which will be of ever-changing interest to them, in the pursuit of which they can serve their brother doctors and themselves, namely, the activities of their county and state medical societies.

SOME ESSENTIAL FACTORS IN THE DIFFERENTIATION OF FUNCTIONAL AND ORGANIC DISORDERS OF THE CENTRAL NERVOUS SYSTEM

By H. H. DRYSDALE, M.D.,
CLEVELAND, OHIO

IT HAS been and still is the custom of many to designate disorders of the central nervous system, organic or functional, as if there was a line of demarcation or some essential difference between them but science does not recognize any such distinction, the difference being usually temporary and one of convenience. Gross organic lesions are of course well established clinically and adequately understood. Such conditions are capable of being felt, seen, or otherwise demonstrated.

In the realm of functional uprising the situation is quite reversed. Their mechanisms are not only changeable, complex and variable but are largely subjective. Moreover, they may be the expression of an organic affliction in process of development. The intelligent interpretation of this multisymptomatic group is rarely easy. On the contrary, no other medical problem lends itself to so many discordant conceptions. A conservative physician therefore exhausts every means at his command before pronouncing a disorder functional and then does so only provisionally, in the meantime keeping his patient under close observation. In other words what today might be regarded functional may at some later date be explained in terms of neurophysiology.

Economically as well as therapeutically the prompt recognition of any disease constitutes a solemn responsibility on the part of every medical man. With modern laboratory and *X*-ray facilities at our command in practically every community, few patients, even during the incipiency of their infirmities should find it necessary to tarry long for a final diagnosis. This equally applies to lesions of the central nervous system. And yet organic conditions continue to be classified functional or confounded with other somatic disturbances. Parkinson's disease for example, despite its prevalence, is frequently overlooked until the cardinal symptoms have reached maturity. Only recently two cases of over one year duration were treated at great cost in prominent sanitariums for hypertrophic arthritis of the spine. Shuffling of the feet plus diminishing alertness in a previously healthy individual should be sufficient to point the way to a prompt diagnosis. It is seldom necessary to await the development of pill-rolling tremors and statuesque rigidity of face and body. Much of the confusion that prevails in this regard could be avoided if physicians subjected every patient to a complete and painstaking physical survey. By so doing they would undoubtedly elicit at least one significant sign before the malady progressed very far.

The diagnosis of intracranial neoplasms is also a problem of grave concern. No two cases are exactly alike but with modern methods of approach their detection and approximate localization is not ordinarily long delayed. Nevertheless, there is a certain percentage of cases whose manifestations are so obscure and atypical as to tax the ingenuity of the most highly skilled. Extensive growths especially cysts have been exposed by operation or necropsy which were objectively symptomless.

In all suspected cases a cautious observer will, with the cooperation of an experienced ophthalmologist, be constantly on the lookout for such signals as papillitis, ocular motor palsies, ptosis, pupillary deformities, dysarthia, diplopia, nystagmus, hemianopsia, perimetric field defects, motor and sensory anamolies, Kernig sign, slowness of cerebration, vomiting, Foster Kennedy syndrome and increase of spinal fluid pressure. If the diagnosis cannot be established clinically there is still recourse to encephalography which is capable of disclosing gross lesions otherwise not discernible. In this connection it is well to appreciate that convulsive insults are frequently the intitial symptom of brain tumor and oftentimes lead to an incorrect diagnosis of epilepsy when the growth lies close to the motor areas. By the use of encephalography a clear concept of the pathologic process is attained and this constitutes a most important aid in differential diagnosis.

Cerebral lesions such as tumor, abscess and ventricular block may also be definitely located by means of ventriculography but this is a procedure which should remain in the hands of the neurosurgeon to whom the operable brain tumor patient is eventually referred.

At this point permit me to digress for a moment and discuss briefly the contention of several responsible clinicians that certain cases of so-called post-traumatic neurosis, are explainable on the basis of organic changes in the brain that can be visualized by encephalography. It is unmistakably true, as I heretofore intimated, that roentgenographic studies made possible by the lumbar insufflation of air to replace spinal fluid are

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capable oftentimes of unmasking gross lesions such as neoplasms with startling accuracy but in the appraisal of diffuse processes the element of error still prevails. This probably is attributable to the fact that deformities of the convolutions while entirely normal, cast shadows which are apt to prove misleading.

During the past two years I have had under close observation two cases in which a diagnosis of post-traumatic neurosis was certainly justifiable. Both were victims of severe concussion without fracture of the skull. Subsequently these patients were subjected to encephalographic investigation which allegedly disclosed cortical brain atrophy. I accepted these findings but to my utter surprise both individuals made complete recoveries within four months and resumed their usual occupations. In my judgment it is not possible for a degenerative process of this nature to abate in so short a time. We should therefore hesitate to classify post-traumatic neurosis organic until cerebral pneumographic interpretation reaches a higher degree of efficiency. A diagnosis of this sort implies a dark prognosis which if not sound is eminently unjust to the patient and most unfair to the defendant.

Disseminated or multiple sclerosis is perhaps one of the most important organic diseases of the central nervous system. It is predominantly a disorder of youth although it frequently develops during the third and fourth decade of life. A fully matured case usually presents the following syndrome:—scanning speech, intention tremor, spastic paraplegia of varying degree, exaggerated tendon reflexes of lower extremities, loss of abdominal responses, bilateral ankle clonus, bilateral extension toe reaction with stimuli as applied by the methods of Babinsky, Chaddock, Oppenheim and Gordon and a bilateral rotary nystagmus plus temporal palor of the discs.

Some of these manifestations are clinically suggestive of paresis (paralytic dementia), such as tremor and impairment of speech but when carefully appraised are found to be distinctly different in the two diseases. The tremor in paresis is inconstant, the single oscillations unequal and not closely allied with voluntary movements. The speech is not scanning but syllable-stumbling. In addition there are mental changes in paresis which tend to appear early while in sclerosis they are comparatively slight even in the terminal stages. Chorea may be readily excluded by the character of the tremors. The absence of nystagmus, palor of discs and dysarthria will eliminate spastic spinal palsy. Diffuse myelitis, encephalomyelitis and encephalitis are frequently confounded with multiple sclerosis particularly when they develop as sequela of influenza. Many times it is well nigh impossible to reach a dependable conclusion until the acute phases subside.

The central nervous system as well you know is exceedingly susceptible to the ravages of syphilis. Statistics serve to indicate that neurosyphilis begins probably not later than three years after infection. It develops surreptitiously and may first manifest itself by obtrusive symptoms, by slight objective symptoms or be actually asymptomatic. Asymptomatic cerebrospinal lues is approximately twice as prevalent in white as in colored patients. In a considerable number of early cases, however, significant omens abound such as sluggish, irregular and pinhole pupils in conjunction with certain subjective complaints, i. e., restlessness, insomnia, irritability, lassitude, ease of fatigue and anxiety states all of which are of inestimable value in predicting the presence of neurosyphilis. Unfortunately they are sometimes disregarded especially if the patient denies having lues and is otherwise robust and alert.

Then again considerable misunderstanding may arise when non-specific organic maladies develop in a patient with concomitant syphilis. The Parkinsonian syndrome for instance may appear in later life on a luetic basis but is distinguishable by the presence of signs denoting involvement of other parts of the central nervous system which are not affected in idiopathic paralysis agitans. Under these circumstances the problem concerns two distinct and independent pathologic entities occurring in one and the same patient. It is also worthy of note in this connection that the symptomatology of neurosyphilis has in recent times undergone a profound modification. The violent manifestations heretofor encountered have lost much of their intensity. The old tabetic with his classic "girdle sensation", "gastric crisis" and "electric pains" plus addiction to narcotics is also passing from the scene and I rather imagine that the medical student of three decades hence will look upon tabes as a disease of antiquity. All of this is the result of the effective campaign being waged against syphilis, which has for its chief purpose the prompt elicitation and intensive treatment of the disease in its incipiency. Fundamentally of course the symptomatology of neurosyphilis remains the same and its prompt interpretation is rarely troublesome. A careful study of the spinal fluid by an experienced serologist will tell the true story with quickness and dispatch.

Pernicious anemia: While the semeiology of this rather widespread affliction is fairly well understood, the fact that fully 80 per cent of patients suffering from the disease develop combined degeneration of the spinal cord has proved bewildering to the unwary and to those who are not in the habit of making thorough physicals. Symptoms of combined sclerosis may precede or follow the advent of pernicious anemia and perhaps parallel the achlorhydria which is usually present. The gradual onset of progressive ease of fatigue, increasing numbness and tingling extremities (paresthesia) plus diminished knee jerks,

ataxic movements, impaired vibratory and position sensation, Babinsky toe response and spasticity are sufficiently classical to maintain the diagnosis subject to hematologic and serologic confirmation.

Sciatica: Maladies grouped under the designation "Sciatica" continue to be a source of misunderstanding as the term is loosely applied to every conceivable painful affection along the distribution of the sciatic nerve. Obviously if our therapeutic management of these conditions is to be intelligently directed it is expedient and necessary to determine whether the disability is true sciatica—a primary mononeuritis or radiculitis—or a neuralgia emanating from, or symptomatic of morbid processes the most important of which are osseo-arthritic changes in the lumbar articulations, hip, lumbosacral and sacroiliac joints, pelvic inflammatory states including the prostate, foci of infection, lumbar strain, spasms of the buttock, diabetes, gout, rheumatism, and neoplasms of cord, meninges, and cauda equina.

In making the differentiation it is well to remember that primary sciatica is practically always unilateral. If it happens to be bilateral and diabetes is excluded it is more than likely secondary to some underlying organic lesion. Sciatic neuritis causes no muscular paralysis and no gross sensory loss. It may diminish or abolish the ankle jerk but never the knee jerk. The pain is entirely confined to the posterior aspect of thigh and leg. In true sciatica there is no limitation of passive motion with one possible exception—Lasēque sign—which consists of pain and resistance on extending the affected leg at the knee and flexing the thigh at the hip joint. This reaction is almost pathognomonic of the sciatic nerve syndrome. The symptoms of hip-joint and sacroiliac disorders often resemble those of sciatic neuritis but the pain is more local and confined to the joint or joints and their contiguous soft parts. The ankle jerk is not affected. Patrick's sign is also helpful in this connection. With a patient supine on a level surface flex the thigh of the painful limb, place the heel on the opposite patella and exert pressure on the flexed knee. When positive there is a painful response in the hip or sacrum. This procedure involves flexion, abduction, external rotation and extension and will catch more cases of arthritis of the hip-joint than any other test except the *X*-ray.

Lumbago is limited to the lumbar group of muscles and is therefore a rare cause of diagnostic error. Tabes may be excluded by the bilaterality of the pain, the pupillary irregularities and the negative serology. Pains throughout the lower extremities induced by flat feet are occasionally confounded with sciatica but the wearing of properly adjusted arches will not only effect a cure but make the differentiation. In medico-legal entanglements the simulation of sciatica is not uncommon but a vigilant medical examiner with the assistance of a competent radiographer and orthopedist is unlikely to be misled.

In the diagnosis of epilepsy physicians should never fail to realize that it is an irretrievable injustice to inflict an individual with the stigma of this disorder until every vestige of doubt has been removed. Furthermore a final opinion should never be expressed until the patient has been diligently studied and observed long enough to determine if the symptoms have been repeated. Unless the seizures are repeated they cannot be said to be epilepsy. Moreover, many of the abstruse motor detonations occurring in hypersensitive children and especially those who have been unduly pampered or shut-in are not necessarily epileptic but oftentimes none other than defense mechanisms originating from innumerable physical and mental irritations. Hence an impacted bowel, worms, teething, colitis, phimosis, infectious diseases, trauma and emotional perturbations may incite in neurotic youngsters disturbances that bear some of the earmarks of idiopathic epilepsy.

If true epileptic attacks do arise in conjunction with the above conditions it may be inferred that the nervous system of the child was innately destined for convulsions. It is also significant in this regard that only 2 per cent of epileptic children show a positive Wassermann reaction. Grand mal seizures while they differ in several inconsequential aspects pass through practically the same phases and if personally witnessed by an experienced physician are readily and correctly identified. The sudden loss of consciousness heralded by an aura, the patient falling instantaneously to the ground, first in a tonic and then clonic convulsion with eyeballs rolled upwards, face blue and livid, body bathed in perspiration and frothing at the mouth followed by deep slumber from which the victim emerges with complete amnesia for the event constitutes a fairly accurate portrayal of the average grand mal assault.

Minor disturbances such as petit mal vary in their behavior and are therefore easily mistaken for other somatic infirmities. As a rule they are characterized by momentary loss of consciousness, generally without any aura; but the patient never falls and the body does not convulse. Convulsions developing during the first week of life are for the most part attributable to intracranial hemorrhage. About 50 per cent of these cases terminate in epilepsy. Spasmophilia and tetany are sometimes difficult to separate from idiopathic epilepsy but the true nature of the symptoms can usually be evaluated by the calcium content of the blood and the time of onset of the seizures. In epilepsy there is little if any change in the blood calcium concentration and the paroxysms do not ordinarily appear until the patient is three years old. In spasmophilia the quantity of calcium in the blood is subnormal and the attacks appear most frequently during the first eighteen months of life. Differentiation between epilepsy and fainting is

also a stumbling block at times. Fainting however is not associated with convulsive movements and recurrences can almost always be ascribed to a definite factor such as anemia, low resistance, cardiac weakness, indigestion and stress. The attacks cease when the cause has been removed.

Some epileptics have their attacks only at night (nocturnal) and the condition therefore may pass unrecognized for years. A spot of blood on the patient's pillow is often the first cue. Moreover, certain persons come into the world possessed of an epileptic constitution and pursue their lives without a convulsion. They are however easily aroused and subject to accessions of unmotivated anger which sometimes reach a state of actual furor or frenzy. These episodes are the equivalent to a convulsive insult and the offspring of such individuals frequently develop grand and petit mal syndromes.

A complete physical survey including modern clinical and laboratory tests make possible the differentiation between idiopathic epilepsy and the motor paroxysms that commonly arise as sequela of tumor or abscess of the brain, cerebral hemorrhage, thrombosis, embolism or softening, cerebral arteriosclerosis, neurosyphilis, cerebral trauma, brain sclerosis, chronic alcohol, strychnine and lead poisoning tetanus, eclampsia, heart block, intoxications and febrile disturbances. When major convulsions appear for the first time after the third decade of life they are usually symptomatic in type and should arouse the suspicion of an organic lesion.

Pyknolepsy (Friedmann-Heilbronner syndrome) a self limited disorder of childhood is very apt to be diagnosed epilepsy for the very good reason the attacks are oftentimes indistinguishable from ordinary petit mal. The following points may prove helpful in making the differentiation. In pyknolepsy the seizures are of uniform mildness and never become convulsive. Despite the frequency of the insults, as many as forty or more a day, there is no tendency to intellectual or moral deterioration. The condition makes its appearance during the ages of four and twelve and fails to respond to anticonvulsant drugs. The seizures cease spontaneously and so far as is known never reappear. Once the age of puberty has passed without the occurrence of epileptic symptoms, the diagnosis of pyknolepsy as opposed to epilepsy may be made with certainty.

Hysteria may be introduced not only as a superlative exponent of the so-called functional group but the most protean ailment in the whole field of medicine. There is indeed hardly a sign or symptom of structural disease which hysteria cannot imitate. It is pre-eminently a disorder of adolescence and early adult life. A diagnosis therefore made after the fortieth year, except in constitutionally unstable, morbidly impressionable individuals, should be entertained with extreme circumspection. Twenty years ago we looked to Paris—to Babinsky's clinic—if we craved to see hysteria in all its glory. Today it is rampant throughout the civilized world. It would seem that the higher we ascend the ladder of personal progress and civic and national achievement, the more luxuriously it flourishes. No race of people are hysteria proof; none can rightfully claim immunity. Despite the fact the majority of cases are neuropathically blighted, the hysteric mind is not by any means a dull or inefficient one. On the contrary many who have reached enviable places in art, literature, science, business and professional life become victims of hysteric casualties when they overstep their limitations or from brain fag find themselves unable to hold in check their inherent susceptibility to morbid suggestions and other stimuli.

It is customary to classify hysteria under two divisions:—minor and major. The minor affairs are of little moment and need not be elaborated here. In a word they comprise mood or affect changes, personality difficulties, eroticism and an inability to adjust at the adult level of reality. Major hysteria manifestations usually appear in the form of monoplegia, paraplegia, hemiplegia, hemianesthesia, anesthesia of vagina, rectum, nose, mouth and pharynx, stocking and glove anesthesia or paraesthesia, amblyopia, monocular diplopia, irregular contractions of the visual fields, dysarthria, dysphagia, aphonia, anosmia, globus, vomiting, somnambulism, phantom pregnancy (pseudosyesis) coccydinia, contractures, fugues and convulsive anamolies.

Monoplegia, paraplegia and hemiplegia occurring in a young adult with normal cardiovascular integrity, blood and spinal fluid negative, bladder functions intact, deep and superficial reflexes responsive and equal, pupils and eye grounds healthy, sensibility preserved in all its qualities, provided there is no indication of wrist drop, foot drop, spasticity, ataxia, clonus, Babinsky phenomenon, ptosis, facial asymmetry, reaction to degeneration or cranial nerve involvement, would warrant the assumption that hysteria prevails. Remember too that the hysteric gait is nondescript, bizarre or pseudo-ataxic, the legs being flung in all directions. This alone may suffice to clinch the diagnosis. Hoover's complemental test will also help to clear up doubtful cases. Benumbed sensation of one entire half of the body with no cutaneous overlapping (hemianesthesia) developing as an isolated symptom is always a functional problem. The same may be said of stocking and glove anesthesia. Hysteric amblyopia, dysarthria, dysphagia, anosmia, aphonia, tachypnea, astasia- abasia, glossodynia, globus, vaginismus and contractures occur under such suggestive circumstances that their psychogenic origin is plainly evident from the very start. Various cues and stigmata are habitually present to confirm it.

Hysteric convulsions are not only disquieting

happenings but a source of considerable perplexity, especially if the constitutional and personal makeup of the subject is unfamiliar to the physician. Under such conditions major insults may appear alarming when the trance-like state is unduly prolonged. It is therefore well for the inexperienced observer to keep in mind that the hysteric rarely suffer a seizure in public unless the emotional shock has come with such sudden and overpowering force that she could not combat it. Usually she will strive to fight it off until shelter is found and then chooses a soft spot on which to fall. She therefore rarely injures herself, never bites her tongue or froths at the mouth and seldom loses control of bladder functions, unless wilfully. The convulsion itself is not characteristically tonic or clonic but the patient thrashes about, bangs, jerks and rolls around. There is usually little if any change of pulse rate and no hyperhidrosis. The entire scene is apt to be grotesque, often histrionic. After the storm abates and poise is regained she will, if honest, relate practically all that transpired during the attack. Sometimes surface anesthesia is so profound that a needle can be deeply inserted into the soft parts without apparent painful reaction and it is difficult to understand why the punctured wounds do not bleed.

Major hysteric syndromes may be differentiated from cerebral hemorrhage by the absence of the usual signs of cardiovascular degeneration, by the normal temperature of the body, the undisturbed pulse rate, the conservation of the deep reflexes and quiet breathing. The circumstances under which the symptoms developed and the age of the patient also has some bearing.

Pure hysteria is never a serious affair, never jeopardizes life, and yet you should know that it may be the occasion of the first attack of angina pectoris, apoplexy, hepatic and renal colic in a subject whose heart, blood vessels, kidneys and brain have been undermined by structural disease. By reason of vasomotor phenomena and the spasmodic contractions that an upsetting emotion brings in its train certain symptoms may be started up which hitherto existed potentially in the individual thus affected.

In the domain of gastrointestinal disturbances psychic influences also exercise a tremendous role etiologically and are most commonly expressed anatomically along the vegetative nervous system through stimulation or inhibition of the parasympathetic organization and occasionally of the sympathetic system itself. The Russian, Pavlov, has demonstrated this more convincingly than any other scientist. With the distribution of the vagus from the epiglottis down to the rectal mucosa, in the event of emotional stress everything is possible in the way of symptoms, i.e., tachycardia which simulates thyroidism, epigastric pain or colic suggestive of appendicitis, gastric ulcer, cholecystitis, renal calculus, ovarian disease and other visceral states, etc.

Statistics are also on record from well recognized clinics, health centers and dispensaries which indicate that fully 75 per cent of Jewish patients are without appendices, their gall bladders under indictment and the symptoms still persisting with new ones tacked on. If this is true our skill in classifying structural and functional disorders of the gastrointestinal tract leaves much to be desired.

Little fault, however, should be found with our management of the organic, as clinical, laboratory and roentgen ray facilities are capable of eliciting pathologic processes within the abdomen with a marked degree of reliability in the vast majority of cases. It may therefore be conceded that our deficiencies concern the interpretation of subjective syndromes which are not due to an antecedent bodily lesion but the result of a faulty working nervous equipment or the expression of conflicts or disharmonic uprisings within the psychic sphere. Unfortunately, there are still amongst us many who instinctively and unqualifiedly subordinate the disturbances of the mental to those of the physical. It is difficult for them to rise above deep-rooted pathologic convictions. Had they been prepared when exhaustive examinations proved negative to seek an explanation elsewhere—to study the individual not only from the standpoint of his complaints but to survey him as a whole—many honest sufferers would not be flocking to the shrine of the cultist who holds forth in every community. They deserted medicine because we failed to understand them, and their number is legion.

Then again when rebellious neuropaths fail to respond to a carefully and sometimes ingeniously devised plan of therapy some physicians overestimate the significance of foci of infection as causative factors and as a matter of last resort recommend the extraction of teeth, enucleation of tonsils, gastric lavage, colonic irrigations, etc. Of course it is advisable and expedient to promptly remedy all offending physical defects but a progressive medical man appreciates that no hysteric, anxiety or conversion symptom was ever cured that way and it is equally true that all these attempts only serve to confirm the neurotic in his distress and to perpetuate symptoms which are amenable to psychotherapy. Whatever success does attend these heroic methods may be credited to suggestion.

Finally, I may add that it would be a herculean if not an impossible task for me to touch even the high spots of a subject of such magnitude within the allotted time. My remarks therefore have been confined to a brief discussion of some of the every-day problems the modern physician is called upon to solve. It is my hope that enough has been said to stimulate an interest in each and everyone of you which will encourage a more careful ap-

praisal of the neurological material that crosses your path. The intelligent differentiation of functional and organic disorders of the central nervous system necessitates a detailed psychological study plus a painstaking physical investigation of every patient. This is scientific medicine—a responsibility the physician should be prepared to meet.

1105 MEDICAL ARTS BUILDING.

HYPOGLYCEMIA; ITS GROWING CLINICAL IMPORTANCE

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THE hyperglycemia of diabetes mellitus, due to deficient hormone-production by the islets of Langerhans, has long been recognized. The opposite condition of hypoglycemia, due to excessive production of the islet hormone (hyperinsulinism) or perverted secretion (dysinsulinism) is gradually assuming considerable importance in clinical medicine. This communication is addressed particularly to general practitioners, because it is in this field of medical practice that such cases will be encountered most frequently.

Shortly after the introduction of insulin by Banting, Harris reported the first cases in which the names hyperinsulinism and dysinsulinism were applied to those cases in which consistently low blood sugar levels were found. Clinical experience and research during the past decade has done much to clarify our understanding of carbohydrate metabolism, particularly as regards hypoglycemia. It has become increasingly apparent that hypoglycemia is a relatively common entity. It is equally evident that it often passes unrecognized. This is particularly unfortunate, since the diagnosis may be made with ease, and the institution of proper treatment yields gratifying results.

Hypoglycemia may manifest itself in many ways. No patient should be stigmatized with the diagnosis of epilepsy until the possibility of hypoglycemia has been eliminated. Many patients exhibiting manifestations of mild psychotic disorders will be found to have a low blood sugar level and will improve remarkably when this condition is adequately overcome by proper therapy. The diagnosis of hysteria, neurosis or neurasthenia should not be made until this possibility has been excluded. Hypoglycemia is a common cause of exhaustion or collapse after vigorous physical exercise. Behavior changes in both children and adults are often associated with a decline in the blood sugar level, and often respond promptly to increased carbohydrate intake. The alert and highly efficient individual who suddenly becomes dull, lethargic and inefficient is not infrequently a victim of spontaneous hypoglycemia. The same may be said of individuals who exhibit less prominent manifestations of fatigue, exhaustion and inability to "keep up with the crowd."

The obese individual whose carbohydrate intake is greatly curtailed during reduction treatment, and who experiences great weakness and exhaustion, is often suffering from hypoglycemia. The patient who responds badly to thyroidectomy is often found to be in hypoglycemic shock. Prolonged fasting is inevitably followed by a drop in the blood sugar level. Long continued infection frequently lowers the blood sugar level. Many cases of so-called cyclic vomiting of children and some cases of persistent vomiting of pregnancy are due to hypoglycemia and respond promptly to correct management.

An appreciation of the mechanism involved in this disturbance of carbohydrate metabolism is essential in any consideration of diagnosis and rational therapy. Glycogen is the main carbohydrate of the tissues, while glucose is the chief form of transportable carbohydrate in the blood. It has been estimated that all the free glucose in the body would be burned during fifteen minutes of vigorous exercise, if it were not constantly renewed from the glycogen storehouses. Under normal circumstances, the body contains about ten times as much glycogen as glucose. While glycogen is found in all of the cellular tissues, it is most abundant in the liver, where it serves as a readily available reserve store for the rest of the body. Next after the liver as the important storehouse of glycogen is muscle tissue. Sansum and Woodyatt found that a man weighing 70 kilograms is capable of utilizing glucose at the rate of sixty grams per hour; only about fifteen grams per hour were required to meet the demands of the basal metabolism in the resting subject. Consequently, about forty-five grams per hour, or 75 per cent of the injected glucose, was apparently stored as glycogen.

The glycogen stored in the liver, and to a lesser degree that retained by muscle tissue, serves as a source of supply of glucose for the maintenance of normal carbohydrate concentration of the blood and the glucose requirements of the tissues. The transformation of glycogen into glucose is termed

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glycogenolysis. This is effected through the medium of enzyme activity (glycogenasis) which is stimulated by one or more of several external agencies. The factors which stimulate glycogenolysis are: 1. fall in the blood sugar level, either from exercise or insulin production; 2. epinephrin secretion; 3. thyroxin secretion; 4. disturbance of the acid-base balance to the acid side; 5. stimulation of the "sugar center" in the floor of the fourth ventricle; 6. ether anesthesia; and 7. asphyxia.

Hepatic glycogen must first be transformed into tissue glycogen before it is capable of supplying the energy requirements of the body. Insulin appears to be a necessary reagent in this transformation. The tissue glycogen which is stored in the muscle tissue is utilized to furnish the glucose of combustion and the resultant energy. This glucose plays no part in maintaining the proper carbohydrate level of the blood. There are two factors which tend to lower the blood sugar level: 1. decreased hepatic glycogenolysis and 2. increased tissue glycogenolysis and utilization. Decreased hepatic glycogenolysis results in a lowering of the blood sugar level because the glucose derived from the liver glycogen is not readily mobilized.

One or both of two clinical causes are usually responsible for decreased hepatic glycogenolysis. The first of these occurs in that clinical state in which the glycogenolysis process is depressed due to marked diminution of the available hepatic glycogen. This is observed particularly in hypothyroidism, myxedema and cretinism. Depression of hepatic glycogenolysis may occur immediately following thyroidectomy; this can be avoided if the patient has been fortified with adequate carbohydrate food prior to the operation. Slender, asthenic, undersized individuals often experience marked fatigue, associated with a low basal metabolic rate, but without other evidences of hypothyroidism. Such persons do not respond well to thyroid extract, particularly if the blood cholesterol values are normal. If it is found that the blood cholesterol is low, thyroid administration will produce improvement. Hypoadrenalism as observed in Addison's disease is frequently associated with low blood sugar values. The hypoglycemia which follows extensive burns has been attributed to suprarenal dysfunction. If the liver itself is diseased the amount of stored glycogen will be reduced, depending upon the extent of destruction of liver cells. This is observed in extensive cirrhosis of the liver, particularly when the cirrhosis is of the obstructive biliary type. The severe hepatitis which often accompanies chronic cholecystitis frequently results in well-marked hypoglycemia, particularly after cholecystectomy under ether anesthesia.

Spontaneous hypoglycemia occurs occasionally in diabetics and is attributed to a depletion of the hepatic glycogen. In the extensive hepatic disease which accompanies phosphorous, chloroform or carbon tetrachloride poisoning, depression of glycogenolysis is common. A similar disturbance occurs not infrequently following the administration of salvarsan or other arsenical preparations. Severe infections, such as diphtheria and scarlet fever, frequently produce low blood sugar values either from their depressant effect on the liver or on the adrenal glands. Acute yellow atrophy and extensive carcinomatosis of the liver are often associated with diminished blood sugar values.

The second group of clinical conditions which produce lowering of the blood sugar level includes those diseases which cause increased utilization of glucose by the tissues. This is particularly observed after the convulsive seizures which accompany strychnine poisoning, eclampsia and tetanus. Here the hypoglycemia is primarily due to the extraordinary demands on the glycogen stored in the muscles due to the increased muscle activity.

Hyperinsulinism, whether it be from the over-administration of insulin or from the over-production of islets hormone by a pathological pancreas, produces hypoglycemia. Hypoglycemic symptoms arise when the blood sugar level reaches 60 to 45 mg. per 100 cc. The pathological conditions of the pancreas which are now known to be capable of producing hypoglycemia are hyperplasia, adenoma or carcinoma of the islets of Langerhans. The adenomatous condition of the islets may be very small in extent, but yet may cause severe hypoglycemic symptoms. Because of the small size of the tumors which have been found in some cases it is thought that the insulin produced by the abnormal islet tissue is qualitatively stronger than that formed by the normal islets of Langerhans. Hence the perverted function of the abnormal islets of Langerhans is sometimes termed dysinsulinism rather than hyperinsulinism.

In some cases of acromegaly and of Fröhlich's syndrome, the diminished pituitary secretion may be responsible for the production of hypoglycemia. Insulin and pituitrin are regarded by many as antagonistic in their action, so that diminished pituitrin production may produce relative hyperinsulinism. Hypoglycemia of moderate degree is often associated with status thymicolymphaticus and progressive muscular atrophy.

ONSET AND COURSE

The onset of hypoglycemia is usually insidious. In certain instances, however, an initial attack of hypoglycemic crisis, with complete loss of consciousness, may occur without warning. Ordinarily, mild episodes usually precede the development of the symptoms of marked hypoglycemia. The most frequent onset symptoms are attacks of exhaustion and faintness, which gradually increase in intensity and are accompanied by profuse perspiration, trembling, and numbness of the tongue and lips. The course of the disease is usually

chronic, with recurring exacerbations. The prognosis depends upon the ultimate etiology and the severity of the condition, the time at which it is recognized, and the institution of proper therapy.

The attacks usually appear at regular intervals. In mild cases, weeks may pass with little or no manifestation of the disease. In the more extreme cases attacks may recur daily or even several times a day; in such cases hourly feedings, day and night, may be necessary to overcome them. Strenuous physical exertion or intense mental application often precipitate attacks. In such cases a hard day's work may be followed by intense weariness, mental confusion and collapse. Headache is often present. The demand for carbohydrate food often produces an intense feeling of hunger.

Milder attacks of hypoglycemia are often seen in individuals who return to their homes almost completely exhausted after the day's work, but who are promptly revived by the ingestion of a meal. Anxiety and depression are common symptoms. Contrary to rule, occasional individuals will manifest an antipathy for food and sugar. The psychic manifestations of the disease frequently dominate the clinical picture. Hallucinations are not uncommon. Certain persons will become greatly agitated, will shout, burst into tears, jump out of bed, and attempt acts of violence. Amnesia is occasionally observed. Mild epileptiform muscular contractions, particularly of the muscles of the face, are not uncommon. The sense of fatigue and exhaustion is often so intense that the patient feels unable to move. Complete loss of consciousness usually represents a late stage in the series of symptoms. Coma occasionally comes suddenly. During coma the pulse usually remains strong and regular; the skin is pale, but one feature of this type of coma that is most characteristic is its rapid termination when glucose is administered. Leyton states that he has had 500 cases of hypoglycemia under his care and that the most important symptoms are those related to the mental state. Some of his patients behaved as if they were demented or intoxicated with alcohol.

DIAGNOSIS

The most important consideration in the diagnosis of hypoglycemia is to think of it. If one is familiar with the manifestations of the disease, the diagnosis is not difficult. The most frequent symptoms of hypoglycemia are those which are now so well known as being due to overdosage with insulin. The most important diagnostic consideration is to determine the blood sugar level *at the time of the attack.* When it is not possible to secure the blood during the attack, the specimen should be taken in the morning on a fasting stomach. Sometimes it may be of value to withhold food for a day and have the patient indulge in exercise before doing the blood sugar test. The intensity of the symptoms may not coincide directly with the extent of the fall in blood sugar values. Some patients may not exhibit symptoms until the blood sugar reaches the level of 35 mg. per cent.

In the differential diagnosis a variety of general and nervous disorders must be considered. The intense feeling of hunger, with food relief, may cause confusion with duodenal ulcer. Without doubt many persons who have been treated for peptic ulcer, without roentgenographic confirmation, have actually suffered from hypoglycemia. Epilepsy, brain tumor, and cerebrospinal syphilis might easily be confused with the cerebral manifestations of hypoglycemia. It seems apparent that many of the symptoms of hypoglycemia are due to an interference with brain nutrition, with the production of anhydremia and cerebral edema. Many patients who have been labeled with the unsatisfactory diagnoses of neurasthenia, neurosis and hysteria have been found to be victims of hypoglycemia.

TREATMENT

The mild attacks of hypoglycemia are ordinarily promptly overcome by the institution of six to eight feedings a day instead of the usual three. The immediate treatment of an attack is the administration of glucose. In coma, the intravenous administration of glucose is required. In conscious patients, the ingestion of food rich in carbohydrates will usually suffice.

Weil has obtained good results with meals relatively low in carbohydrate and high in fat content, based upon the theory that fatty foods provide less of a stimulant to the islets of Langerhans than carbohydrates.

Drugs are of relatively little value. Epinephrin in doses of 0.25 to 1 mg. is useful in the treatment of attacks but must be followed at once by glucose. Pituitrin, although it exerts some antagonistic effect on the production of insulin, has not proved to be of great value. If enough thyroid substance is administered to maintain an elevation of about 20 per cent above the normal basal metabolic rate, the tendency to attacks is diminished, but the disadvantages of continuing such medication are obvious.

Surgical treatment is indicated when there is reasonable certainty of a neoplasm of the islets of Langerhans. If, after a thorough dietary regimen the patient does not improve, an exploratory operation is probably advisable.

ILLUSTRATIVE CASES

CASE 1. A twenty-two year old unmarried woman complained of exhaustion, marked nervous instability and generalized aching. She had been quite well until six months previously when these symptoms had their onset. The nervous symptoms were those of repeated emotional disturbances, associated with crying spells, introspection and a marked sense of depression. The exhaustion became so marked that the patient felt forced to re-

main in bed. After complete bed rest for eight days she was able to resume some activity, but the nervous instability persisted. While at work the day before observation she suddenly felt cold and lost consciousness for several minutes.

The patient was ordered to the hospital for diagnostic study. The history revealed little of importance up to the beginning of the present illness. Her appetite for food was excellent; in fact, she often craved food. She had had periods of palpitation, shortness of breath, and short attacks of epigastric distress.

The physical examination was essentially negative. Hematologic studies, urinalysis, Wassermann and Kahn reactions, basal metabolism studies, and *X*-ray films of the skull, chest, heart, and teeth revealed no abnormalities. The blood chemical analysis showed normal values with the exception of the blood sugar determinations. At the time of the first examination the blood sugar level was 65 mgm. per 100 cc.; at this time the patient was feeling quite well. A few days later, however, she had an attack of marked prostration and a feeling that she was about to lose consciousness; at this time the blood sugar value was 50 mgm. per 100 cc. The intravenous administration of 50 cc. of 50 per cent glucose solution at this time produced marked immediate improvement. Daily chemical analyses of the blood during the following four days indicated that the blood sugar level was never higher than 66 mgm. per 100 cc. She was then placed upon a diet rich in carbohydrates, which was soon followed by a restoration of the blood sugar level to the normal range. For slightly over one year this patient has remained on a diet rich in carbohydrates and has experienced no recurrence of the symptoms of hypoglycemia.

CASE II. A nineteen year old girl came under observation because she complained of inability to sleep, marked emotional instability, exhaustion and introspection. Her school work had caused her great concern and she was constantly aware of her excessively nervous reaction to ordinary occurrences. During the preceding several weeks the symptoms had become exaggerated. On the day prior to the first observation, she felt particularly exhausted and felt that she was about to lose consciousness.

Several of her relatives had had diabetes and there was a history of thyroid disease in two members of her immediate family. She had had pneumonia during childhood. Her appetite for food was excellent. The menstrual history was normal. She experienced brief episodes of coughing associated with dyspnea and palpitation. The tonsils had been removed.

A thorough physical examination revealed no abnormalities except for acne vulgaris. The blood studies, urinalysis, Kolmer and Kahn reactions, and *X*-ray studies yielded no significant information. The blood chemical analysis showed normal values with the exception of the blood sugar, which was 67 mgm. per 100 cc. She was admitted to the hospital for observation. Daily blood sugar analyses were made; one estimation was found to be 80 mgm. per 100 cc.; six other estimations showed values from 60 to 63 mgm. On the third day of the period of observation she had a marked attack of nervous instability, faintness and exhaustion; the blood sugar estimation made on this day showed a value of 50 mgm. per 100 cc.

This patient was then placed upon the treatment discussed in the text of this paper. Improvement occurred promptly and has persisted during the six months that she has been under observation. She has had no recurrence of the symptoms of hypoglycemia during this period.

CASE III. A forty-two year old man presented himself because of shortness of breath, nervousness, headaches, palpitation and attacks of exhaustion. He had experienced attacks of shortness of breath during the previous three weeks, associated with shooting pains in his head. He had lost an indeterminable amount of weight. He stated that during the previous two years he had experienced several fainting spells, always preceded by a marked sense of weakness and a ravenous hunger. He had discovered that these symptoms were relieved by eating food. On several occasions he had been awakened from sound sleep with a feeling that he was approaching unconsciousness; such attacks were always relieved by eating several slices of bread. On several occasions he had become completely unconscious. These attacks had always occurred between meals. He had observed considerable tremor of the hands.

The physical examination revealed no essential abnormalities except for a moderate degree of dental caries and a slight soft symmetrical enlargement of the thyroid gland. At the first observation his blood pressure was 212/110; after three weeks of bed rest the blood pressure was 150/90.

Blood studies, urinalysis, Kolmer and Kahn reactions, renal function test, electrocardiographic tracings and *X*-ray films of the chest revealed no essential deviations from the normal. The blood chemical analyses revealed no abnormalities except the blood sugar values. The first blood sugar estimation, done the morning after a fifteen-hour period of fasting, was 60 mgm. per 100 cc. Daily blood sugar estimations for the next five days averaged 60 mgm. The intravenous administration of glucose solutions brought marked immediate improvement in all symptoms. The patient was placed upon a diet rich in carbohydrates, but the improvement in this case is not as complete as in the cases previously described. The fact that the low blood sugar values persist in this case, with only partial relief of symptoms, suggests the possibility that there might be a small tumor of the pancreas. Exploratory operation has been advised but the patient has not accepted the suggestion.

New Drugs-Cosmetic Bill in Hopper

Hearings are now being held by the Committee on Commerce of the United States Senate on S. 2000 introduced by Senator Copeland, New York, and providing for a new code for Federal regulation of the foods, drugs and cosmetic industries and distribution of such products. S. 2000 is a modification of and substitute for the so-called Tugwell Bill which Senator Copeland introduced and sponsored at the last session of Congress and which had been strenuously opposed by the foods, drugs and cosmetic industries as too drastic and establishing objectionable bureaucratic control in the Department of Agriculture. The compromise proposal endeavors to meet the objections to the former measure raised by reputable manufacturers of these products but contains regulatory provisions intended to protect the consumer and give the government greater authority to prosecute the manufacturers and distributors of dangerous and worthless products. Washington observers predict that S. 2000 or some such similar measure will be enacted before Congress adjourns.

PSYCHOANALYTIC TREATMENT OF NEUROSES SIMULATING MEDICAL CONDITIONS

By ALAN D. FINLAYSON, M.D.,
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SACHS*, speaking of psychoanalysts, in a recent article says, "Every medical man long before the Freudian days knew that the individual cannot be divided into a body and a personality since it is a psycho-biological entity . . .; for many of the guild write and talk as though there had been no appreciation of psychic influence over somatic functions until their arrival on the scene." The writer agrees with Dr. Sachs but believes that the medical man does not put this knowledge into practice always in his everyday clinical work. Further, it is believed that this is the attitude of most psychoanalysts.

It is a matter of common knowledge that the neurotic reacts more violently to whatever ailment he may have than the normal individual. The neurotic will have a slight cut on his finger. He will treat it with a great deal of care, wrap a large bandage around it and keep it dressed for perhaps days after the need has passed. The normal individual will paint the wound with mercurochrome and perhaps put on some tissue paper to stop the bleeding or maybe nothing at all. Similar reactions might be enumerated indefinitely.

The knowledge of the reaction of patients to emotions such as fear, pain, rage, etc., are also a part of the professional equipment of every physician, but again he does not always use it to the advantage of the patient. It seems that medical education of former days and of the present as well lays more stress on the physical side of the patient, almost to the exclusion of the personality.

I wish to present a case showing the physical manifestations of a neurosis, and explain briefly the underlying dynamics of these physical manifestations. Time will not permit me to go into detail about the minutia of the dynamics, the method of investigation, or the treatment.

In this presentation the facts relative to the illness of the patient are correct, but the identifying data has been changed or deleted. The reasons for this discretion are obvious.

The history presented is of a married man in the third decade, an accountant in a public service corporation, and a college graduate. He has been with this concern before and since his graduation at twenty-two, in all a period of fifteen years, and was considered efficient up to about eight years ago, or immediately following his marriage.

His father died when the patient was in the early twenties of what was diagnosed as angina pectoris. His mother is living at 65 but a semi-invalid from heart trouble.

The patient was the second of three children, the older and younger siblings being girls. The older girl was the father's favorite and was a brilliant student. The patient always tried to equal or excel her scholastic record, a fact which accounted not a little for his good grades. Another factor was his fear of authority in the form of his teachers. The youngest girl was a favorite of the mother. At the birth of the younger sister the patient refused to kiss his mother goodnight until forced to do so by the father. The patient resented this very greatly. Up to the time of the birth of the younger sister he had felt he was the favorite of the mother and looked on the newcomer as a rival for the mother's care and affection, and wished the new baby out of the way. His unconscious wishes toward the new baby will he brought out in the analysis later.

As a child he was a bed wetter for some years. His father apparently entertained a pathological anxiety about him and was constantly cautioning him to watch where he was going and what he was doing. He was not allowed to enter into boyish games that entailed any element of risk such as playing baseball with a hard ball. That his mother was very solicitous for his safety was shown by her not allowing him to play near a barge which was close to his home as the barge men might kidnap him. From this exaggerated solicitude on the part of both parents taken with their real or fancied preference for his sisters, is it any wonder that he early developed the feeling that the passive feminine attitude toward life was preferable and more gratifying?

He early developed a variety of fears, of the dark, of authority, of animals, both domestic and wild and the latter was great enough so that he never visited a zoo until recent years. This same fear prevented him from visiting a circus. He was also thrown into a panic at the sight of trapeze performances in a circus.

The first day of school throughout the grades caused a gastro-intestinal upset and many times resulted in his not going, or coming home early. He was obsessed in school with the fear that he would have to leave the room to urinate and would be refused permission. The fact that it never happened did not lessen the fear.

At the age of eight he began to have phantasies of spanking little girls. For a time this existed

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*Sachs, Bernard, Amer. Jour. Psychiatry, Vol. XII. No. 4, 1933. Page 726.

in phantasy only but later was carried out in reality, accompanied by erections. One little girl he had spanked developed pneumonia and died. He developed a severe conscience reaction, feeling he was responsible for her death. The spanking of little girls continued, and at the age of thirteen he began to have an accompaniment of orgasms and ejaculations. When in bed he would get a quilt between his legs, phantasying it was a little girl and produce an ejaculation this way. The quilt would rub his genitals but he never masturbated in the usual way although he considered this method the same as masturbation. He developed fears relative to this practice, thinking he was harming himself physically, mentally and morally and that God would and did punish him for his moral derelictions. This practice continued up to the beginning of the analysis with all the accompanying fears.

Girls never had any sexual appeal for him. He never petted but once and then the girl was probably the aggressor.

At the age of 17 the first one of his physical symptoms, a sudden spasmodic cough, made its appearance and it persisted until the beginning of the analysis. The circumstances under which it first appeared, and was frequently repeated, was following an evening spent with a girl friend. After marriage it appeared under other conditions. He felt this was an indication of tuberculosis, a punishment visited on him because of onanism.

Early in his college work he intended to study medicine but later he became interested in the religious activities of the college and gave up the thought of medical work, thinking he would become a missionary. During college he had two experiences with evident homosexuals. The experiences were very revolting to him. The experience consisted of the patient merely having his genitals handled.

During his college years he met his future wife, then a student in a college in an adjacent city. He saw her quite frequently but the suit was frowned upon by her parents because of a difference in nationality and religion. The courtship was entirely devoid of conscious sex feeling and sex play on the part of both. The marriage was an elopement as far as the bride's parents were concerned and has never been wholly condoned by them. The patient's illness which began immediently after marriage has been one of the chief reasons for their continued antagonism. The onset of the acute symptoms of the patient's neurosis began within a week following marriage.

The first system was a severe stomatitis which persisted for six months and accompanying it was a feeling of physical and mental inadequacy. During this six month period he was away from his work more than he was there.

The wife was frigid from the start and penetration was not accomplished for about six months. During this time the patient would have erections sometimes with ejaculations. After he had penetrated he usually would not have an ejaculation but if he did it would be without any sense of satisfaction but rather a feeling of frustration. The phantasies of spanking little girls continued and he admitted he got his only sex satisfaction from them. He blamed the continuance of these phantasis on the lack of satisfaction in coitus. These phantasies continued in spite of his fear of the results of maturbation. In the past few years the object of his phantasy has been his secretary, a girl in her late teens. He frequently substituted this girl in fancy for his wife, when having intercourse with the latter, with or without the spanking element.

Within a year after marriage he began to have a great deal of nausea and vomiting and gastric distress, so much so that he became afraid to eat, especially in company. At noon instead of eating in a men's lunch room he would get a small lunch and go away by himself to eat. If he tried to eat with the group he would either lose his appetite or his lunch. At dinner time at home he either would not sit down with the family but have his dinner served alone in his room, or if he did sit down he would usually excuse himself when part way through and lie down or have the remainder of the meal served in his room.

Part of his work was attending directors' meetings, some of which were luncheon meetings. He was uncomfortable at any of these meetings but more so when lunch was served. He would get restless and fidgity and have to leave the meeting several times to urinate or defecate. This frequency and urgency of urination and defecation dated back to his school days and was a constant source of anxiety whenever he attended any gathering. It became more pronounced after marriage. His work also demanded some mixing with men at clubs, golf courses, etc,, but he had to give them all up after marriage as he became afraid of being nauseated, feeling weak and faint or actually fainting. He developed a fear of traveling on street cars for the same reason and to a less extent, automobiles.

He was under observation and treatment by the family physician for a period of two years for this gastro-intestinal disturbance and finally an appendectomy was advised and done to remedy the condition. There was a cessation of the symptoms for about a month and then they reappeared with increased intensity and continued unabated for a period of over five years up to the first month of the present treatment.

About a year before this psycho-analytic treatment began the patient developed sensations of pain and paraesthesia in the left chest, left arm, left leg and his left foot would feel ice cold as if it were asleep. Then there were periods when he felt he had a tachycardia. The family physician diagnosed the condition, according to the patient,

as angina pectoris, the disease of which the father died. He was given some medicine, the nature of which is unknown to the essayist and advised, again according to the patient, "to give up his work and live the life of an old man with heart trouble." Coincident with the paraesthesia of the left side of the body there was a burning sensation in the eyes, nose, lips and throat. Whether on the advice of the attending physician or independent of it, the patient consulted a nose and throat specialist and underwent some surgical procedure in both these fields, to correct the sensations, but with no benefit.

During the six months prior to the essayist's observations the patient developed a fear of jumping out of high windows and wouldn't accept a room in a hotel above the second floor. He was afraid to be alone when shaving and insisted on his wife being with him during this operation, if he were at home, or would have a hotel employee with him if he were at a hotel.

He developed a pathological anxiety relative to his little girl, that she would be killed by an auto, or kidnapped. If she had a knife or scissors in her hand he would become panicky.

As time went on the patient became more self-centered, introspective and feared insanity. He was irritable at home and because of his fear of heart trouble he did very little of the work about the home ordinarily devolving on the man, such as caring for the lawns, furnace, etc. He even asked if it would be injurious for him to run a carpet sweeper. The wife did her own work and most of what should have been his. When he would feel ill he would go to his mother's home for several days for a "rest" on the pretext that it was quiet there, but in reality it was because he felt more comfortable there and he thought his mother understood what to do for him better than his wife.

He was diffident about entering into a controversy even if he were in the right. He had anxiety dreams in which he was pursued or punished by some man in authority yet much of his other dream material showed a definite underlying aggression toward his entire family. He was conscious of being inefficient in his work, constantly upbraiding himself for his inefficiency and feared he would lose his position, but was apparently powerless to remedy the situation.

The patient was advised by a friend to seek psychiatric help and wrote for an appointment. It was suggested to the patient that it would be the courteous thing to apprise his attending physician of his contemplated action. Before the date set for the appointment arrived the physician had dissuaded him, repeating the advice again, to lead a sedantary life and it was several months before he came under observation.

During the nearly eight years that had elapsed since the patient's marriage with the onset of the acute symptoms, he had not worked over a month continuously without having one or more days off because of the symptoms previously given, and on many occasions he had been away from work for a month or more.

The dynamics underlying this patient's neurosis of which his symptoms were the subjective manifestations are briefly these: We have an individual with a specific family configuration, two domineering parents, an older and a younger sister, real or fancied favorities of the parents, and the patient feeling an outsider as far as emotional gratification from the parents was concerned; who in his formative years was doomed to the conflict which has been his lot until recently. This individual was extremely passive in his daily living but carried out his aggression through phantasies and dream life relative to his parents, sisters and wife, even though these dreams were fraught with much anxiety, fear and recrimination.

His marriage, an attempted escape or cure for his masturbation was his supreme effort to assert his masculinity but since this was in defiance of authority, the wife's parents, it resulted in even greater anxiety. The tension produced by this anxiety was in a measure released by an almost complete denial of his attempted masculinity. The expression of this denial was the acute exaccerbation of the symptoms. He then proceeded to conduct himself in his professional work, his home and his marital relations, not as a man but a weak helpless female child who couldn't work consistently to support his family, who was unable to do his share in keeping up the home or satisfy himself or his wife by adult sexuality. Instead he now had a legitimate excuse, his illness, to escape from reality and escape he did back to the parental home and to his mother's arms where he would find protection from the outside world and no demands would be made on him. Here all was peaceful.

In the past eight months this picture has materially changed in that he has been able and willing to do his share and more of the work of the home, the irritability toward, and apprehension about his wife and child have disappeared. He has been able to perform all of the duties pertaining to his position easily, the gastro-intestinal symptoms have disappeared as well as the frequency of urination, the paraesthesias of the body are absent and the burning sensation of his lips, nose and throat are gone and only a slight subjective sensation persists in the eyes, but this has lost its emotional charge. He doesn't resort to spanking phantasies but his sex life is still unsatisfactory as the wife is still frigid. He is able to listen to radio programs or visit the movies when the theme has to do with crime and punishment without any untoward emotional response. There has been a marked gain in weight, and finally he has not lost a day's work in this period

in spite of the fact that his concern has been in such financial condition that he might lose his position at any time and he has had a 50 per cent reduction in salary.

In the light of this improvement, under analytic treatment, with financial conditions which are usually considered sufficient in themselves to produce a "nervous breakdown", is it not logical to raise the question, if the appendectomy and tonsillectomy were justifiable, and if they were not justifiable is it not also pertinent to ask, if the patient was not made worse by these procedures?

A case of this type emphasizes again the fact that only when the physician, whether he be general practitioner or specialist, takes cognizance of the personality of the patient, whatever the objective or subjective symptoms may be, can he arrive at a true picture and be able to apply rational therapeusis.

10515 CARNEGIE AVENUE.

DISCUSSION

CARL F. ULRICH, M.D., Cleveland: In his excellent paper Dr. Finlayson has portrayed the conflicts that were revealed and the results obtained in an all too common type of neurosis. The physical symptoms have yielded to treatment by psychoanalysis. His patient has been restored, a productive member, to society.

The physician in general practice frequently sees such patients, the psychoanalyst usually only after the patient has gone from physician to physician, dispensary to dispensary. Cultists thrive on such patients. Occasionally one reads of the brilliant results the cultist has obtained, always "after all doctors had failed". These results are transient. One never hears or reads of the ultimate recurrence of all the old symptoms together with the appearance of a few new ones that follows this miraculous cure.

These patients are excellent salespeople. They have studied and observed their symptoms unceasingly and have read all the available "doctor books". If the physician is governed alone by the symptoms the patient presents, it is probable that he will arrive at a true diagnosis only after he has seen various methods of treatment fail or have only a transient effect. The patient by then may have gone elsewhere to repeat his experience.

Laboratory procedure may be necessary to establish a careful diagnosis. The repetition over and over of tests in order to convince the patient that he is not suffering from organic disease is valueless, and needlessly increases the cost of medical care.

Two instances will illustrate this point: A patient complained he was unable to eat certain foods. When he took milk, eggs, chocolate, beef, turnips he suffered from discomfort, pain, nausea. An elaborate blindfold test was devised for him. He was given foods by stomach tube. His reactions to them were carefully noted. His response to the test foods bore no relation to the previously noted food idiosyncrasies. It was demonstrated to him that he had not complained when he was fed milk, eggs, chocolate, beef and turnips, but that his complaints had fallen alike upon foods accepted and those he ordinarily rejected. He was shown that in two instances he had complained of nausea at one trial and of no symptoms in repeated trials of the same food. His response was that he still could not eat milk, eggs, etc.

A young artist had failed in examination. He was sure it was because of his physical condition. He was anemic. He was carefully examined by a careful diagnostician and was told the results of blood counts that had been done. He was assured that he was not physically ill. The patient went to the nearest druggist, purchased a bottle of liver extract capsules, brought them to the table at dinner that evening and explained to the family that he was suffering from severe anemia.

It is important that the physician see the patient as a total personality not simply as a vehicle for intriguing symptoms. Such a point of view must be presented to the medical student early in his curriculum, before his therapeutic horizon becomes too limited. We can then hope for earlier diagnosis, prompt treatment and minimum cost for the medical care of these patients.

A Cleveland Study On Confinement Cases and Maternal Mortality

Highspots of a study of 16,000 confinement cases in Cleveland in 1931 to determine the chief factors contributing to deaths of women in connection with childbirth are reviewed in a recent issue of *The Survey*, under the heading, "Why Mothers Die".

The study was made by Dr. Richard A. Bolt, director of the Cleveland Child Health Association, in cooperation with the Cleveland Academy of Medicine, Cleveland Division of Public Health and the Visiting Nurse Association.

The following seven general conclusions were reached by Dr. Bolt:

1. Factors entering into puerperal mortality are so interwoven with the social, economic and cultural fabric of the community that it is impossible to evaluate them without detailed study of each individual case.

2. Comparison of maternal mortality rates for different communities is misleading unless definition of terms, methods of collecting data and interpretation of records are comparable.

3. Deaths following abortion should be separated from deaths after twenty-eight weeks of uterogestation to gain a true picture of the situation.

4. The midwife, aside from abortions, plays a relatively minor role in contributing to the high maternal mortality rate.

5. Sepsis, toxemias and hemorrhage play the major tragic roles, and these are associated largely with hurried, operative and bizarre obstetrics.

6. Prenatal care and hospitalization are accessories to the actual obstetric situation. They may not be associated with a low maternal mortality, depending upon the type of medical, nursing and hospital care afforded.

7. Not every maternal death is, at present, preventable. Fundamental changes must take place in the socio-economic order and more complete knowledge and skill be available in order to approach this ideal.

THE TREATMENT OF POSTPARTUM HEMORRHAGE

By S. J. GOODMAN, M.D., F.A.C.S.
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"There is no obstetric emergency that so seriously jeopardizes the patient's life, that calls for such sure and prompt treatment for its relief, and in which all the courage, resource, and skill of the obstetrician are so suddenly put to the test, as in a severe case of postpartum hemorrhage."—DeLee.

The hemorrhage that is considered in this paper is that terrible deluge of blood following delivery, which shakes the accoucheur's nerve to its foundation, and which in a few minutes may drain the circulatory system of the patient. Some obstetricians hold that this is a wholly preventable accident, but I cannot subscribe to this teaching, since it occurs in the practice of the very best obstetricians.

In view of the fact that there is generally no warning of this disaster, it is most important that the physician shall be at all times prepared to act promptly and energetically when it suddenly confronts him. For the so-called postpartum hemorrhage, in the home or hospital, the usual kit carried by the doctor usually will carry him through safely; but I am considering a uterus which, while not seriously lacerated, fails to contract or retract, remains flabby and atonic, and with unclosed sinuses and full of clots. For these cases, and in addition to his regular armamentarium, the doctor should have on hand plenty of hot water, *a pan of cracked ice*, a *good* fountain syringe, a *good* needle for the instillation of salt water into the tissues or veins, aseptic ergot and pituitrin, a clear-headed nurse, and last, but not least, he must appreciate the urgency of the situation and act wisely and *quickly*.

I need not enumerate the symptoms of postpartum hemorrhage to this group of obstetricians; you know them well. The thing to do is to *act*. What is the first thing to do? If you wish to be mildly amused when you go home ask your nurses, internes or fellow staff members, just what they would do if suddenly confronted with this condition.

"*Throw back the covers and look*". I repeat, *look*. Feel the uterus. Never mind the pulse; it will not avail to count it. Then "*turn out the clots*," by firm pressure upon the uterus. This advice is not new. It was given by Meigs and Hodges in the days when they were ridiculing Oliver Wendell Holmes for his views on puerperal sepsis; it long has been a tradition at Jefferson Medical College.

"*The only safe uterus is an empty one*." If this maneuver is temporarily successful, ergot and pituitrin may be given hypodermically, but should the bleeding not stop, or start afresh, insert the hand into the uterus and irritate its walls while continuing firm compression with the other hand; and "*turn out the clots*." If still unsuccessful, carry a piece of ice into the cavity of the uterus, and continue to manipulate it.

In former days we were handicapped in the home by the lack of ice, but today almost every home has a refrigerator.

Except in rare instances, I never undertake a delivery without a pan of cracked ice in the delivery room. Some will maintain that the woman will surely be infected by the introduction of the unsterilized ice. But is it practical to scrub the hands anew, sterilize instruments and prepare the vulva when suddenly confronted with this deluge of blood? Certainly not. Better treat the possible sepsis than perform an autopsy.

The above method—the insertion of the hand into the uterus, the turning out of the clots, the introduction of ice—has been successfully used for a long time in Grant Hosiptal.

I have not suggested packing the uterus for the control of such hemorrhage. We do not believe in it at Grant Hospital. Dr. Baldwin has taught us the fallacy and futility of packing the womb in such emergency. It reminds him, he says, of the efforts of Mrs. Partington to push back the waves of the Atlantic with her broom. I must admit that nearly all text-books advise such maneuver, but that is simply because nearly all text books are merely copies of previous publications. I have emphasized the sudden onset of this hemorrhage; the frightful torrent of blood; the lack of time to prepare to combat it; the quick passing of the patient; but suppose that you are already aseptically prepared to pack the womb; that you have every agent for this technic near at hand; that your nurses are trained by you for such emergency; while you are filling the womb with gauze, the womb will be filling with blood, and expanding until rupture occurse or the patient is dead.

The advocates of packing claim that if that procedure fails, the technic is faulty. My answer is, that if it is successful it is because the hemorrhage is not the kind of postpartum hemorrhage I am talking about. That I am not alone in this contention is evidenced by the opinion of Dr. J. F. Baldwin, Dr. Wm. S. Smith, of Brooklyn, and many others. In a recent paper, Dr. Smith says:

Read before the Section on Obstetrics and Pediatrics, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7-8, 1933.

"It is evident that the intra-uterine packing is not necessary in the prevention, or treatment of postpartum hemorrhage. The only safe uterus is an empty uterus."

The principal reason for the failure of the uterine pack to control postpartum hemorrhage is that the strips of gauze are too small, the obstetrician is rarely equipped to act instantly, it takes too long to get the patient into position for packing, and the womb is filling with blood while the gauze is being inserted. The patient dies before any result is obtained.

We have lost patients from postpartum hemorrhage, but we are convinced that we have lost less than have those who have resorted to packing. I have several times controlled a postpartum hemorrhage for other doctors, only to have them start the bleeding anew by packing the uterus as a prophylaxis against further bleeding. In all such cases, the patient died.

In conclusion, I offer the following: Teach your nurses and internes to *instantly recognize* the onset of a true postpartum hemorrhage; to *grasp the womb and hold it firmly; to turn out the clots.* To you, I recommend that you insert the hand into the uterus and, if necessary, introduce a piece of ice; do not pack the uterus with gauze to control a real postpartum hemorrhage. This hemorrhage cannot be foreseen and we should *always* be prepared to meet the emergency with a pan of ice near at hand.

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THE VALUE OF VITAL FACTS

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THE term vital statistics means the statistical record of facts which pertain to life and death in any given community. The term is sufficiently comprehensive to include the records of the smallest village or those of a nation.

Vital statistics may be said to constitute a science, and such a science as requires a very considerable knowledge of mathematics, mnemonics and nosology to master it. It has been well defined by the statement that it comprises an analysis and synthesis of facts, concerning the life history of the population.

The necessity of registration and the value of vital facts is so evident to one engaged in the work that it is a real pleasure to present this paper. It is almost like urging that drinking water should be pure or that we should continue the efforts to control contagious diseases.

The origin of life statistics is of great antiquity. The seed which has developed into our present system was brought into this country by our forefathers. Recording a birth is a custom which is as old as civilization. It was practiced in the Roman Empire at the foundation of the Christian era, and has been continued ever since by town or parish clerks, notary publics or clerks of the church, until now it is a government function mostly under the Department of Health.

The original objective of birth registration in England, which was performed as early as 1538, was to prevent disputes regarding inheritance, but it was not until 300 years later or in 1837 that systematic records were kept by the Registrar General, which was made compulsory in 1876.

The earliest record of a system of vital statistics in the United States was that of the colony of Massachusetts Bay, almost 300 years ago and only ten years after the founding of the colony.

The practical utility in the history of communities is very great and is increasing every year. Any community which pretends to keep a record of its doings must have vital statistics. It not only enables a community to know where it stands, but where it stands in comparison to other communities.

It informs those who seek such information the prevalence of disease and death, the frequency of birth. It suggests the need of sanitary measures for the relief of insanitary conditions. It encourages habits of careful observation and thoughtfulness on the part of those by whom statistics are provided, and it is the foundation for the census, the first being taken by our government in the year 1790.

The New England states along with Michigan and Pennsylvania were the first to have a compulsory registration law. Ohio did not establish a system of registration of births and deaths until December 20, 1908.

By an act of the legislature in 1856 the recording of births was placed under the jurisdiction of the Clerks of the Common Pleas Courts. Assessors, clergymen, physicians and midwives were made responsible for reporting them at the close of the year. In the year 1867 the legislature provided that these records should be filed in the offices of the Probate Judges of the different counties. Two years later the responsibility of reporting these records was given over entirely to the assessors.

Read before the Section on Public Health and Preventive Medicine, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7 and 8, 1933.

Chief, Division of Vital Statistics, Ohio State Department of Health.

There was also a general Act permitting boards of health to establish and maintain a system of birth registration and twenty-two cities were collecting births when the present registration law became operative. The first was Cleveland in 1873, second, Cincinnati in 1874.

The state is now divided into registration districts with 1150 local registrars to whom the physicians and midwives must report the births they attend within ten days from the date of birth. This is in conformity to the model registration law, under which Ohio is operating. Better registration would be had if the reports were made within 48 hours after birth.

Much has been written and said about the nation's decline in birth rate. From our system of birth registration, we are enabled to give you the following facts. During the past quarter of a century Ohio's birth rate per 1000 population has declined 25 per cent and at a time when there has been an increase in the population of 39.6 per cent, or 1,887,303.

In Ohio today we have 1,565,342 women between the ages 15 and 45 years. This is known as the childbearing age. Seventy-two per cent of this population lives in the urban districts or in cities of more than 5,000 population; 28 per cent of this number is found in the rural districts. One woman in every 14 gave birth to a child last year in the cities, as compared with one woman in every eight in the rural districts, which indicates that the rural population is still maintaining its ratio of births.

The birth rate of Ohio continued to rise and fall since the establishment of registration, maintaining an average level until the year 1924 and from then until the year 1929, during our very good times, the rate declined 18 per cent, and from 1929 to the close of the year 1932, there was a decline of only 6 per cent in the rate per 1000 population.

One of our great declines in birth registration is among children of foreign-born mothers. During the past twenty years Ohio's birth rate for children to foreign-born mothers has declined 38.9 per cent, as compared with only a decline of 13.6 per cent in our native birth rate.

I believe the majority of the people realize the importance of birth registration, for there is hardly a relation of life, social, legal or economic in which the evidence furnished by accurate registration of births may not prove to be of the greatest value, not only to the individual but also the public at large.

A birth certificate proves the age, citizenship, right to passport, school enrollment, labor protection, the right of inheritance and many others. The people of our state must depend upon the medical profession for the immediate and accurate filing of a birth record, for 98.2 per cent of all our obstetrical cases are under the care of a physician.

I want to discuss the death certificate, for it is from the cause of death that we collect the information which proves the value of medical research and education along the lines of preventive medicine, also safety campaigns for the prevention of accidents. The death record for mortality statistics is probably prepared with a greater degree of accuracy because the medical profession has been schooled to the importance of death records.

The registration of burials goes back to the time of Cromwell of England in 1538, the records being kept on the parish registers. In 1839 the registrar general took over this important duty and in 1874 a law was passed making it punishable by a fine of ten pounds or penal servitude or imprisonment for two years for failure to report a burial.

The Bureau of the Census published the first mortality statistics in the year 1850. The medical certificate of death is of more value to the medical man than to any other. It is the best opportunity you have to study a collected number of causes of death and to realize the results of your study and efforts in your work of preventing sickness and death.

How would we know if it were not for the records filed in the Department of Health, Division of Vital Statistics, that deaths from cancer are continually on the increase, and 25 years ago tuberculosis ranked first as a cause of death and was written on every ninth death certificate, but today it ranks seventh as a cause of death and can only be found on every twentieth death record?

Yes, this record has other values. It guides the home seeker in selecting a safe and healthy community in which to live. It guides industry in selecting the location for their plant. It protects inheritance, and the protection given by insurance did not become general to the people until the actuaries had vital statistics on which to compute their calculation. There are three kinds of vital statistics, local, state and federal. The local represents the city or county in which you are studying.

The old statement that anything can be proved by statistics is no longer true. They are just as accurate as the information written upon the original records is correct. The process used in the study of vital statistics is very simple. Collect and classify the facts; make comparison and conclusions from the study of the facts, and the results will be just as accurate as the original information written upon the original birth and death certificates.

We are all striving today to prevent sickness and prolong life. Death must come at sometime. Medical science seems to be inclined more and more to the belief that a good physical patrimony is the greatest of all assets for the man who would live a ripe old age. We all know that we have increased the average life span by cutting down

death among children, young men and women, but if the individual is to live longer we must go beyond birth and give him a good inheritance.

In 1910, 11,463 children did not live to have a birthday. Last year only 5957 died under one year of age. Among this group 2753 died of conditions peculiar to early infancy, such as congenital debility, premature birth and injury at birth.

In 1910, 9.8 per cent of all the deaths were between the ages 10 to 29 years. In 1932 the number in this group represented 9.6 per cent. The noticeable change in the comparison took place in the older age groups in 1910. In age group 30 to 50 years, 13.8 per cent of the deaths occurred as compared with 19 per cent in this group in 1932.

The greatest change, however, occurred in age group 50 to 80 years. In 1910, 32.5 per cent of the deaths occurred in this group, but in 1932 it increased to 58.2 per cent, thus proving that man's enemies in the middle age of life today, as represented by vital statistics are: Heart disease and cancer (all forms), cerebral hemorrhage, nephritis and diabetes, robbing him of the opportunity to live longer than did the man of 50 years ago.

The reason the cosmopolitan papers of today are publishing the news of the number of cases of sickness and death from sleeping sickness in St. Louis is because vital statistics have created an interest on the part of the reading public for news of this kind.

Special studies of all causes of death are available as to race, sex, age, nativity, months and place in the Division of Vital Statistics of the Ohio Department of Health.

We should all urge the prompt and accurate reporting of births and deaths that health be preserved while it can. The day may come when it will be lost, never to be regained.

New Books Received

Mental Hygiene in the Community, by Clara Bassett, consultant in psychiatric work, division of community clinics, National Committee for Mental Hygiene, Inc.; a comprehensive picture of the relation of mental hygiene to some of the urgent problems of community life and of the extent to which mental hygiene approach is being utilized in the study and treatment of social problems; The Macmillan Company, 60 Fifth Avenue, New York; price $3.50.

More than 57 per cent of war veterans' disability cases were found not to be of service connection, the U. S. Veterans' Administration has announced following a review of a consolidated report of the special boards appointed by President Roosevelt to pass on border-line cases. Disability of service-connection origin was found in 21,955 cases of the 51,213 cases reviewed.

Status of Medicinal Liquor in Ohio

Rights of physicians to secure, dispense and prescribe in unlimited quantities for medicinal purposes, medicinal liquor, alcohol, and alcoholic preparations are preserved in the Ohio Liquor Control Act enacted by the Ohio General Assembly late in December.

Section 13 of the Act specifically states that nothing in the Act shall be construed to prevent a duly licensed physician from "administering or dispensing intoxicating liquor or alcohol to a patient in good faith in the actual course of the practice of his profession" or to prevent the sale of alcohol to physicians for medicinal, chemical or scientific purposes.

Druggists holding a Class G Permit may sell medicinal liquor and alcohol upon the written prescription of a physician or to the physician for use in his practice.

This scientific right is preserved even in local territories that might vote "dry" under the local option provisions of the Act in so far as beverage liquor is concerned. Sale of alcohol to physicians by druggists holding a Class G shall be made only upon the written, signed, dated and sworn application of the physician, personally presented by him.

No prescription for medicinal liquor or alcohol or application for alcohol shall be filled more than once by the druggist.

The Southeastern Surgical Congress will hold its fifth annual assembly in Nashville, Tennessee, March 5, 6 and 7. The Andrew Jackson Hotel will be hotel headquarters and the lectures and exhibits will be in the War Memorial Building. The following physicians will occupy places on the program: Fred H. Albee, New York; W. Wayne Babcock, Philadelphia; S. O. Black, Spartanburg; Vilray P. Blair, St. Louis; Frank K. Boland, Atlanta; J. B. Brown, St. Louis; D. B. Cobb, Goldsboro, N. C.; George W. Crile, Cleveland; T. C. Davison, Atlanta; John F. Erdmann, New York; P. G. Flothow, Seattle; Seale Harris, Birmingham; M. S. Henderson, Rochester, Minn.; Arthur E. Hertzler, Halstead, Kansas; Chevalier Jackson, Philadelphia; Walter C. Jones, Miami; Dean Lewis, Baltimore; Joseph F. McCarthy, New York; C. Jeff Miller, New Orleans; A. J. Mooney, Statesboro, Ga.; John J. Moorhead, New York; Edward T. Newell, Chattanooga; Fred Rankin, Lexington, Ky.; Paul H. Ringer, Asheville; Stewart Roberts, Atlanta; George H. Semken, New York; Phil C. Schreier, Memphis; Arthur M. Shipley, Baltimore; H. E. Simon, Birmingham; A. O. Singleton, Galveston; J. R. Young, Anderson, S. C.; Waitman F. Zinn, Baltimore. Dr. B. T. Beasley, 1019 Doctors' Building, Atlanta, is in charge of arrangements.

PHYSICIANS IN PRIVATE PRACTICE AUTHORIZED TO HANDLE CWA INJURY CASES—REGULATIONS GOVERNING HOSPITALIZATION ISSUED

Two important developments relating to medical and hospital care at government expense for persons disabled while employed on Civil Works Administration projects throughout Ohio have taken place within the past two weeks and should serve to adjust certain misunderstandings which arose out of the differences in interpretation of the rules and regulations governing such medical and hospital services and to bring about a more effective and fairer distribution of medical and hospital services for such employes.

First, acting upon instructions from the Federal Civil Works Administration at Washington, the Ohio Civil Works Administration has ordered the Civil Works administrators of every county in Ohio to cooperate with the local county medical society in preparing a list of local physicians, who are willing and qualified to provide treatment to disabled Civil Works employes, to which disabled employes may be sent for medical care in communities where Federal Government medical facilities (Federal hospitals and dispensaries) are not available or are inadequate.

Second, pursuant to orders from the Federal Civil Works Administration, the Ohio Administration has sent to all local Civil Works administrators copies of instructions issued by the Federal Administration governing the hospitalization of disabled Civil Works employes, relative to the selection of hospitals in Civil Works compensation cases, and fixing a nation-wide schedule of rates and fees to be paid hospitals caring for disabled Civil Works employes.

FEDERAL ACT USED AS MODEL

As pointed out in the January, 1934, issue of *The Journal*, pages 46-49, the four and one-half million men and women, approximately 250,000 of whom reside in Ohio, who have been given employment on Civil Works projects and who are disabled through injuries received in or from sickness arising from such employment are to be paid compensation during the period of disability and are to be provided with medical and hospital care at government expense.

Benefits paid to such disabled Civil Works employes are similar to those provided by the United States Employes' Compensaton Act of 1916 and the rules and regulations issued under such act for disabled civil employes normally in the service of the Federal Government, such as postal employes, clerks of local Federal offices, etc. Medical and hospital service for such regular civil employes of the Federal Government has, under the Federal Employes' Compensation Act, been furnished at government expense by medical officers of the Federal Government, by Federal hospitals or dispensaries, or by some 4,000 physicians in private practice specifically "designated" to care for such civil employes in communities where other Federal medical facilities are not available.

On November 27, 1933, shortly after the Civil Works program got under way and several million persons throughout the country were given employment, the Federal Civil Works Administration issued Rules and Regulations No. 5 authorizing the payment of compensation to disabled Civil Works employes and providing them with medical and hospital care. These regulations were superseded by others issued December 12, known as Rules and Regulations No. 5 (Revised). The rules and regulations issued on December 12 are those now in effect and are retroactive to November 16 when the Civil Works program was launched.

INTENT OF RULES MISINTERPRETED

Rules and Regulations No. 5 (Revised), which were analyzed in detail in the January issue of *The Journal*, provided that disabled Civil Works employes should be sent to United States medical officers and Federal hospitals or dispensaries when available; or, in case such Federal medical facilities were not available, to other public medical facilities, either state, county or municipal; or, in case Federal or other public facilities were not available, to "designated" physicians authorized to handle cases coming under the Federal Employes' Compensation Act; or, in case none of the foregoing facilities were available, to physicians in private practice.

The regulations were interpreted by many local Civil Works administrators to mean that no physician in private practice could be employed to treat a disabled Civil Works employe unless the physician was on the government's list of 4,000 "designated" physicians or no Federal, state, county or municipal or "designated" physicians were available in the locality.

Following protests from representatives of medical organization to the Federal Employes' Compensation Commission, administrative agency under Rules and Regulations No. 5 (Revised) of Civil Works compensation cases, relative to the wording and interpretation of the regulations which in effect precluded the free choice of physician even in localities where no Federal medical facilities were available, the Federal Employes' Compensation Administration has issued instructions to the State Civil Works Administrations attempting to clarify and adjust this misunderstanding, which instructions were incorporated in the following letter under date of January 4, 1934

sent to all county Civil Works administrators in Ohio by Major E. O. Braught, executive director, Ohio Civil Works Administration:

SITUATION CLARIFIED IN INSTRUCTIONS

"The following is a telegram from the United States Employes' Compensation Commission, authorizing the employment of any reputable physician in the treatment of Civil Works Administration injured employes:

"'Physicians, designated by the Commission in Form CA 76 to provide medical treatment where government facilities are not available or are inadequate, were not selected in connection with the Civil Works Administration. They were selected for the treatment of civil employes of the United States. The reference in REVISED RULES AND REGULATIONS, NO. 5, of the Federal Civil Works Administration, was intended to furnish names of physicians acquainted with the Federal compensation laws and regulations of this Commission, and not intended to exclude other reputable physicians willing to give treatment at reasonable charges, in accordance with Paragraph 6, of RULES AND REGULATIONS, NO. 5.

"'Notify local administrators at once that they are authorized to advise the local medical profession and organizations accordingly. and to make arrangements to permit REPUTABLE PRIVATE PHYSICIANS to participate in rendering this service, on the basis indicated Regulations governing medical service require the use of government medical officers and hospitals where available, and properly and reasonably accessible.

UNITED STATES EMPLOYES COMPENSATION COMMISSION'."

To further clarify the intent of Rules and Regulations No. 5 (Revised) and to amplify the foregoing interpretation of the rules and regulations by the United States Employes' Compensation Commission, the Federal Civil Works Administration on January 5 issued to all State Civil Works Administrations the following instructions, which in turn have been sent by Major Braught to all county Civil Works administrators in Ohio:

"The list of physicians and surgeons (Form CA-76), designated to provide treatment, where Federal Government medical facilities are not available or are inadequate, was for your temporary guidance only, as indicated by our telegram to you of December 22. (Note: Telegram quoted above).

"Please instruct your local administrations to consult the officers of their County or District Medical Societies at once to enlist the societies' cooperation as follows:

"1. Ask them to share with you the responsibility of preparing a list of the local physicians to be authorized to provide treatment to supplement Federal Governmental medical facilities when these are not available or are inadequate. This list should include physicians in the locality (whether members of the local medical society or not) who are well qualified by training and experience to render compensation service, who are licensed to practice medicine in the state, and who desire to participate in this service under the regulations of the United States Employes' Compensation Commission. These regulations provide for fees not in excess of those charged by physicians generally to patients in the same income class as the injured person.

"2. Have them indicate on this list physicians who, by training and experience, are especially qualified to handle unusual and special types of cases.

"3. Request that they work out with you a mutually satisfactory plan for distributing the compensation work among the physicians on the list in as equitable a manner as possible. Any plan should provide for the immediate treatment of emergency cases, and for treatment by physicians well qualified to handle the particular type of case.

"A cumulative record should be kept which will show the number of cases which have been assigned to each physician on the list."

NO UNIFORM FEE SCHEDULE SET-UP

It will be noted that Rules and Regulations No. 5 (Revised) and the above quoted instructions relative to them *do not call for or contemplate the establishment of a uniform standard schedule of fees for medical services to disabled CWA employes but provide for the charging of fees similar to those prevailing in each community for services to patients in the same income class as injured CWA employes.*

Accompanying this communication from Major Braught to local administrators was an order from the Ohio Civil Works Administration instructing the local administrator to immediately get in touch with the medical society of his county; work with the society in preparing a list of physicians, who are willing and qualified to handle Civil Works injury cases, and upon completion of the list have appended to it the signatures of officers of the county medical society, acting for the medical profession, and sign it himself.

In this bulletin concerning medical care for injured Civil Works employes, the Federal Civil Works Administration interpreted Rules and Regulations No. 5 (Revised) in such a way that most of the objectionable features of the original plan for providing such employes with medical service

ACCORDING to the last audit of injuries and deaths officially reported among persons employed on Civil Works projects in Ohio made by George W. Tooill, chief of the compensation division of the Ohio Civil Works Administration, up to January 1, 2767 CWA workmen had been injured and 12 had died.

These figures were based on reports received from 60 counties in the state. Several counties in which injuries among CWA employes had been reported in the press had not made official reports to Mr. Tooill and such injuries were not included in the foregoing figures.

have been eliminated and various misunderstandings clarified.

As indicated by the orders issued on both December 22 and January 5, the Federal Civil Works Administration is endeavoring to comply in so far as practicable with the intent and purposes of the Federal Government in the expenditure of Federal funds for medical services for the needy unemployed, namely: To have medical care at government expense furnished by physicians in private practice.

As pointed out definitely in these instructions to state administrators, physicians in private practice will be permitted to provide medical service for disabled Civil Works employes in all communities where Federal medical officers or Federal hospitals are not available and in communities where Federal medical facilities are inadequate.

NO PREFERENCE TO "DESIGNATED" PHYSICIANS

No preference is to be given by local administrators in arranging for medical care for injured Civil Works employes to physicians who had been "designated" by the Federal Government to furnish medical care for ordinary civil employes of the Federal Government. Moreover, no preference is to be given to public medical facilities, such as public hospitals, clinics, dispensaries, etc. If Federal medical facilities are not available or adequate, an injured Civil Works employe is to be treated by a physician in private practice or in a private hospital, if hospitalization is indicated.

The present set-up does not provide for the unrestricted free choice of physician by disabled Civil Works employe. However, it does keep the practice of medicine in connection with Civil Works injury cases largely in the hands of physicians in private practice through the contemplated preparation of lists by the county medical society and the local administrators.. Thus the Federal Civil Works Administration has made it possible for injured CWA employes to receive medical care from physicians in private practice which will be the case in most communities since in only a few localities in Ohio are there Federal medical facilities.

Any physician qualified by training and experience to handle Civil Works disability cases can place himself eligible for call by having his name placed on the list prepared by his county medical society and the local administrator.

Government officials have pointed out that because of practical difficulties it may be necessary to keep the lists of authorized physicians in some of the larger centers of population from becoming too large by limiting appointments to those physicians considered specially qualified.

However, it is believed that this will not be necessary in most localities. Moreover, it has been suggested that in the larger cities in preparing the list of authorized physicians, special consideration be given to qualified physicians especially in need of extra work during the present emergency.

COOPERATION OF COUNTY SOCIETY VITAL

It is of vital importance that each county medical society or academy of medicine in Ohio take immediate steps to assist and cooperate with its local Civil Works administrator in preparing a list of physicians authorized to handle CWA injury cases.

The Federal Civil Works Administration's instructions permitting physicians in private practice to do this work will have little or no effect unless medical organization in each community cooperates to the fullest extent in establishing the plan and in making it work.

The government has placed on the county medical societies the responsibility of proposing for such service the names of physicians qualified to handle the type of work involved and in seeing not only that the work is distributed equitably but in insuring to Civil Works employes the best possible medical care.

A considerable amount of detail work in filling out forms, reports and records will be required of participating physicians. For this reason, each county medical society will be rendering their members, as well as the Civil Works Administration, a special service by arranging special instruction by local Civil Works Administrators or other means for acquainting their members with the procedure required in filling out the forms, reports, records, etc.

In this, as in all phases of medical service for the needy and unemployed, considerable responsibility is placed on the county medical society of each community. Some local poor relief and Civil Works administrators are misinformed about or have a misconception of the purpose of the Federal Government to keep the furnishing of medical care to beneficiaries of government aid in the hands of physicians in private practice insofar as practicable and possible. It is the duty of the officials or special committee of each county medical society to keep in close and constant contact with the local administrator so that cooperation can be accomplished whenever possible and misunderstandings on the part of both the administrator and the medical profession eliminated or avoided. Each county has its own peculiar problems in connection with providing medical care for the poor. For this reason, many of the problems which have arisen must be settled by conferences and agreements between the local medical profession and local poor relief officials.

HOSPITAL REGULATIONS ISSUED

Confusion which has arisen as to the hospitalization of disabled Civil Works employes was dissipated to a large extent on January 8 when the Federal Civil Works Administration issued a six-page bulletin of instructions relative to the selection of hospitals in Civil Works injury cases and

CWA MAY BE CURTAILED AS PUBLIC WORKS JOBS INCREASE—PWA (NOT CWA) EMPLOYES UNDER OHIO WORKMEN'S COMPENSATION ACT

AN IMPORTANT question in connection with the Civil Works program of the Federal Government which remained unanswered at the time this issue of *The Journal* went to press was that relating to how long the Federal CWA program would be continued.

Officials informed concerning the financial aspects of the Civil Works program point out that funds appropriated by Congress for these work relief construction projects probably would be exhausted by February 1, or thereabout, and that the entire Civil Works program might end unless additional funds are provided by Congress.

It has been pointed out that the Civil Works program was set up as a stop-gap to provide jobs for the needy unemployed until the huge Federal Public Works Administration program could get into full swing and absorb a large percentage of the millions of unemployed persons throughout the country.

Although Public Works projects are being approved and started in increasing numbers, an insufficient number of such projects has been launched up to the present time to provide work for many of the approximately 4,000,000 men and women now employed on Civil Works jobs.

Government officials are of the opinion that it will be found necessary to extend the life of the CWA program, possibly until May or June, to permit the Public Works program to gain enough momentum to provide employment for the bulk of those doing CWA work.

If, and when, the CWA program is abandoned, those employed on CWA projects will have to obtain employment on Public Works jobs or return to the unemployment relief roll which entitles them to necessities at government expense; unless employed by private employers.

As pointed out in the January issue of *The Journal*, there is a wide difference between Civil Works and Public Works projects.

The Civil Works program provides for the direct payment of employes by the Federal Government on projects under the control and supervision of the Civil Works Administration.

The Public Works program provides for the allotment and loan of Federal funds to political subdivisions for the performance of work by contract, approximately one-third of such funds to be furnished by the Federal Government and the remaining two-thirds by the political subdivision in which such projects are being carried on.

Persons disabled as result of employment on Civil Works projects are paid compensation and provided with medical and hospital care at the expense of the Federal Government under Rules and Regulations No. 5 (Revised), modeled after the United States Employes' Compensation Act.

Those disabled on Public Works projects are given compensation benefits and provided with medical and hospital care in the usual manner by the State Industrial Commission since such employes are in the employment of independent contractors who are contributors to the Ohio Workmen's Compensation Fund and whose employes are covered by the Ohio Workmen's Compensation Act.

Persons unable to obtain work on Public Works projects, if, and when, the CWA program is abandoned, would be provided with medical care under the provisions of Rules and Regulations No. 7 of the Federal Emergency Relief Program which has been analyzed and explained in several recent issues of *The Journal*.

Due to the possibility that a considerable number of persons who are now on work relief and therefore responsible for providing ordinary medical service for themselves at their own expense, may in the near future be forced back upon the relief rolls, it is important that the officials of each county medical society keep in close touch with the situation and continue their efforts to have the set-up providing medical care for the needy unemployed improved and adjustments made in Rules and Regulations No. 7 which will insure the best possible medical service for those on the relief rolls and provide the attending physician with more equitable compensation for his services, as suggested in a statement on the situation adopted by the Council of the State Association at its last meeting on December 17, 1933. (See January issue of *The Journal*, page 40).

the rates to be paid for hospitalization of such cases.

Under the hospitalization program worked out following conferences between government officials and officials of the various hospital associations, injured Civil Works employes must be referred to Federal hospitals when such hospitals are both available and adequate, as required by the United States Employes' Compensation Act of 1916 in cases of injury to any of the regular civil employes of the Federal Government who require hospitalization.

It is not intended to utilize Federal hospitals for Civil Works employes to the disadvantage of other classes of beneficiaries entitled to care in such hospitals nor is this order meant to interfere with the prompt and adequate care of emergency cases in the nearest hospital, it was pointed out.

When Federal hospital facilities are not available or adequate, cases requiring immediate hospital care shall be sent to the nearest suitable hospital which desires to participate in the service at the rates specified by the Federal Government for such service. Public hospitals other than Federal are *not* to be given preference over private institutions.

In determining the suitability of a hospital, the local Civil Works administrator has been instructed to consider the following factors: The proximity of the hospital, the type of service, etc., whether the hospital is well qualified to handle the special type of case, and the general quality of service.

The administrator is to secure advice as to the suitability of local hospitals from one or more of the following local sources: Medical advisory councils, which may already be set up under Rules and Regulations No. 7 of the Federal Emergency Relief Administration; hospital associations, hospitals, health or similar councils, county medical societies, or boards of public welfare or health.

All hospital care must be authorized in writing by the proper officials on the staff of the local Civil Works Administration. Care of emergency cases is not to be delayed for written authorization but such authorization must be furnished within 48 hours after admittance to the hospital.

An authorized physician in charge of the treatment of an injured employe as a compensation patient, when hospital care is required, may send the patient to a hospital of the physician's selection provided the hospital thus selected agrees to the approved schedule of rates. Hospitalization in such cases must be approved in writing by the local CWA administrator.

The U. S. Employes' Compensation Commission, in charge of administering of Rules and Regulations No. 5 (Revised) governing medical and hospital care for injured Civil Works employes, has reserved the right to have its medical representatives examine CWA patients at hospitals; to examine the records of these patients; and to cause the patient's removal when they consider it necessary in the interest of the patient and to prevent overcharge, etc.

BASIC, PER DIEM RATE ESTABLISHED

At the conference between government officials and representatives of the hospital associations, a basic, per diem rate of $3.50 for all hospital cases of injured Civil Works employes was agreed upon, such rate to be general throughout the United States, regardless of local hospital costs or charges but not applying to Federal hospitals. A schedule of rates for hospital services not included in the basic rate also was agreed to.

The instructions issued by the Federal Civil Works Administration and relayed to local administrators by the Ohio Civil Works Administration definitely state that:

"Professional and other fees of persons not employed by the hospital are not included in this agreement."

The following items of hospital service are included in the basic $3.50 per diem rate:

The use of a single room when necessary.
General medical and surgical care by the house staff.
Ordinary nursing.
Special diets.
Usual medicines.
Usual dressings and surgical supplies.
Usual laboratory tests, such as: Blood counts, smears, urine tests, Wassermann tests, precipitation tests for syphilis, Widal tests, agglutination tests, blood typing, coagulation time, haemoglobin estimation, occult blood, skin tuberculin tests, spinal fluid smears and cell counts, sputum examination for tubercule bacillus, and other usual bacteriological tests.
Material for plaster casts.
Colonic irrigations.
Hypodermoclysis.
Such physiotherapy treatments as may be necessary.
Autopsies and reports of same.
Medical and hospital reports unless an actual transcript of the hospital record is requested, in which case the charge for the same should be made in accordance with the local public stenographers' rates.

The basic rate may be charged for the day a patient is admitted but not for the day of his discharge or death.

RATES ALLOWED FOR SPECIAL SERVICES

The following schedule of rates for additional special services was formulated:

Operating room fee: $5.00 for minor operation; $10.00 for major operation.
General anesthetic fee: $5.00 for minor operation; $10.00 for major operation, to include anesthetic service by a salaried employe of the hospital and the cost of the anesthetic.
Laboratory examinations of an unusual character, such as complete blood chemistry, gastric analysis, etc., may be charged for at a rate of from $3.00 to $5.00, according to the nature of the examination (which must be specified in the voucher submitted), $3.00 being the usual charge allowed for such examinations and reports.

Fee for special nursing when necessary shall be in accordance with the local prevailing rate or when furnished by a salaried employe of the hospital, at actual cost.

X-ray examinations at the following rates and required number of films:

	No. of Films	Price
Ankle joint, antero-posterior and lateral views	2	$2.50
Arm, humerus, antero-posterior	2	2.50
Bladder, with injection, antero-posterior	1	5.00
Chest, for pulmonary or cardiac diagnosis, plain	1	3.75
Chest, for pulmonary or cardiac diagnosis, stereoscopic	2	5.00
Clavicle, postero-anterior view	1	2.50
Elbow, antero-posterior and lateral views	2	2.50
Fluoroscopy, when required, without film	1	1.00
Feet, antero-posterior and lateral views	2	2.50
Forearm, radius and ulna, antero-posterior, lateral	2	2.50
Foreign body in eye, location of (the fragment charted in three planes and its dimensions ascertained by the method of Sweet or equivalent as needed)		12.50
Gallbladder, Graham technic, including cost of dye	1	10.00
Gastro-intestinal tract, complete X-ray study, including fluoroscopy, as needed		12.50
Hand, antero-posterior and lateral views	2	2.50
Hip joint, plain, antero-posterior view	1	3.75
Hip joint, stereoscopic, anterior-posterior view	2	5.00
Intestine, barium clysma, 14 x 17 films, for position and outline, as needed		7.50
Jaw, upper or lower	1	2.50
Kidneys, right and left, for comparison, 11 x 14 films, as needed		5.00
Knee joint, antero-posterior and lateral views	2	2.50
Leg, tibia and fibula, stereo-posterior, and lateral	2	2.50
Lipiodol injection for bronchiectasis, etc., including roentgenograms and interpretation, as needed		12.50
Pelvis, 14 x 17, single film, antero-posterior view	1	5.00
Pyrelography, using uroselectan or similar preparation (including cost of drug)	4	10.00
Ribs, plain view over suspects area, 10 x 12 film	1	3.75
Scapula	1	2.50
Shoulder joint, plain, antero-posterior views	1	2.50
Shoulder joint, stereoscopic, antero-posterior views	2	5.00
Sinuses, frontal and ethmoid, antero-posterior and lateral views	2	5.00
Sinuses, mastoid, right and left sides for comparison	2	5.00
Sinuses, maxillary, antero-posterior and lateral	2	5.00
Skull, ventriculogram (air injection) as needed		7.50
Skull, antero-posterior and lateral views	2	5.00
Skull stereoscopic	2	7.50
Spine, cervical, antero-posterior and lateral	2	5.00
Spine, dorsal, antero-posterior and lateral	2	5.00
Spine, lumbo-sacral, with coccyx, antero-posterior and lateral views	2	5.00
Stomach, barium or bismuth meal, 14 x 17 film, after ingestion 4 x 10 films for detection of duodenal cap; total of four 8 x 10 films, including fluoroscopy	4	12.50
Teeth, single film	1	1.00
Teeth, each additional film up to and including five films	1-5	1.00
Teeth, series (five films up to and including full mouth)	over 5	5.00
Thigh, femur, antero-posterior and lateral views	2	3.75
Ureters, right and left, for comparison	1-2	7.50
Wrist, antero-posterior and lateral views	2	2.50

The agreement specifies that unusual expensive medication and appliances should be supplied at cost, including such items as oxygen administration, biologicals, prosthetic and orthopedic appliances, when furnished by the hospital.

Donors in blood transfusions will be paid $5.00 per 100 c.c., and the hospital paid $5.00 for the transfusion.

Ambulance charges when furnished by the hospital may not exceed a minimum rate of $3.00 when the call is within a three-mile radius of the hospital. An additional rate of $.50 per mile beyond the three-mile radius, one way, will be allowed. Arranging costs of transporting patients to hospitals in private conveyances or ambulances is left to the local administrator.

CHANGES IN MEDICAL RELIEF PROVISIONS MAY RESULT FROM STUDY OF DATA

Although during the past two months state and local relief agencies have been concentrating their efforts on establishing the extensive machinery required to make the CWA program function properly, some activities have been started which it is hoped will result in a more effective program of direct relief for those who remain on the relief rolls of the various counties.

Certain phases of the medical relief program established under Rules and Regulations No. 7 of the Federal Emergency Relief Administration have been studied by state and local officials with a view to clarifying some of the provisions of the regulations and making adjustments in so far as possible. During the past month data on the progress of the medical relief program under Rules and Regulations No. 7 in the various counties has been collected from the local relief administrations for the purpose of changes in the set-up if the situation indicates.

In line with the official action of the Council of the State Association taken at its last meeting on December 17 recommending a change in procedure and a substantial increase in medical fees for services rendered to the needy unemployed, a number of county medical societies have submitted convincing arguments to their local emergency relief

directors and to the State Emergency Relief Commission. The Policy Committee and other committees and officers of the State Association have been constantly at work on this matter.

It is considered hopeful that changes will be made in the temporary emergency regulations and that more liberal provisions will be made for medical services to those on the relief rolls. County societies which have not already done so, should immediately confer with their local administrator on this matter and submit to him a summary of the reasons for adjustments in the medical relief program so that state relief officals can have complete data on the situation throughout the entire state. Reports on local developments also should be sent by the various county societies to the State Association Headquarters' Office so that the officers and committees of the State Association will be fully informed on local situations when contacting the state relief officials on these matters.

Thirty-six Applicants Licensed to Practice Medicine in Ohio at January Annual Medical Board Meeting

At a regular meeting of the State Medical Board on January 8 in Columbus, the following officers for 1934 were elected: President, Dr. J. F. Weist, Dayton; vice-president, Dr. J. G. Blower, Akron; treasurer, Dr. F. S. Meck, Cleveland.

Dr. H. M. Platter, Columbus, was reappointed secretary of the Board. Miss Clara F. Brouse was named chief examiner for nurse registration, and Professor S. E. Rasor, Columbus, was reappointed entrance examiner.

By resolution, the Board decided that in the future all complaints from unsuccessful applicants taking examinations given by the Board, should be filed in writing with the secretary, and that the papers of all unsuccessful applicants should be reviewed by the entire Board, and after such consideration, the grades shall be final.

A change in the grading of applicants for certificates to practice the limited branches enumerated in Groups No. 1 and 2 of the Rules and Regulations Governing Limited Practitioners, including chiropractic, naprapathy, spondylotherapy, electrotherapy, hydrotherapy, mechanotherapy, neuropathy, etc., was authorized.

In the future, candidates for certificates to practice these and other Group 1 and 2 limited branches will be required to obtain a grade of at least 60 per cent in each of the fundamental subjects of anatomy, chemistry, physiology, pathology and diagnosis, to obtain a certificate. Heretofore, the grades of applicants obtained in examinations in the above named subjects had been grouped with grades obtained in examinations given in the special examinations covering the limited practice subjects and a combined average of 75 per cent required. Under the new ruling each applicant will be required to obtain a combined average of 75 per cent to obtain a certificate but regardless of his combined grade cannot obtain a certificate if his grade in any one of the five basic subjects, above named, is less than 60 per cent.

Results of the December examinations given by the Board were certified. The highest grade, 87.8 per cent, was made by J. V. Cohn, graduate of the University of Cincinnati, College of Medicine. Second and third places were taken by H. B. Davidson, Ohio State University, with a grade of 86.1 per cent and B. B. Sankey, Hahnemann Medical College, Philadelphia, with a grade of 85.8 per cent.

Thirty-six medical school graduates were successful in the examinations and were granted a license. Certificates also were granted to 11 osteopaths, 2 chiropractors, 2 cosmetictherapists; 9 chiropodists, 3 masseurs, and 7 mechanotherapists.

Those licensed to practice medicine and surgery are:

Harry S. Berlesky, Akron, George Washington University; Joseph Marco, Akron, George Washington University; Thos. L. Laughlin, Jr., Cleveland, Hahnemann Medical College; Lester Rodger Eddy, Ashland, Jefferson Medical College; Wm. T. Sharp, Nelsonville, Jefferson Medical College; Brant Burdell Sankey, Cleveland, Hahnemann Medical College; Rudolph Klein, Cleveland, University of Hungary; Richard L. Smith, Cleveland, Northwestern University; Walter R. Stager, Youngstown, Creighton University; Arthur G. Blazey, Cleveland, Hahnemann Medical College; Robt. E. Slemmer, Cincinnati, Hahnemann Medical College; Theodore A. Krutky, Akron, New York Homeopathic College; Louis J. Tilton, Trotwood, Northwestern University; Tom D. Spies, Cleveland, Harvard University; Robt. J. Semons, Dayton, St. Louis University; Jacques Rosenman, Cleveland, Tufts Medical College; Sam Galinson, Dayton, University of Minnesota; Chas. A. Arneson, Dayton, Northwestern University; Josef Warkany, Cincinnati, University of Vienna; Walter A. Johnson, Toledo, Temple University; Mack E. Moore, Akron, Temple University; Edgar Childrey, Jr., Columbus, Medical College of Virginia; Victor A. Simiele, Columbus, Medical College of Virginia; Harvey A. Karam, Akron, Rush Medical College; Joseph Kraut, Cleveland, University of Hungary; Rolland J. Whitacre, Cleveland, Hahnemann Medical College; Max W. Livingston, Columbus, University of Wisconsin; John A. Knapp, Columbus, University of Wisconsin; Jesse H. Bond, Akron, Jefferson Medical College; Jess V. Cohn, Cincinnati, University of Cincinnati; Hugo Rosenthal, Cleveland, University of Freiburg; Richard C. Wenrick, Cincinnati, University of Cincinnati; Clarence B. Slaughter, Cleveland, University of Toronto; Horace B. Davidson, Columbus, Ohio State University; Herschel H. Pevaroff, Cleveland, Western Reserve University; John Gersten, Columbus, Ohio State University.

FEDERAL INCOME TAX RETURNS MUST BE MADE BY MARCH 15—PROCEDURE FOR PHYSICIANS

Collectors of Internal Revenue in Ohio have mailed to all taxpayers of record, blanks for making Federal income tax returns for the calendar year 1933, which blanks must be filed with collectors on or before March 15, 1934.

Returns should be made in accordance with the provisions of the Revenue Act of 1932.

Congress, now in session, may make some changes in the Federal Income Tax Law. However, up to the time this issue of *The Journal* went to press, no legislation revising the income tax law had been enacted, so those required to file an income tax return should follow the procedure established in the Revenue Act of 1932. In case retroactive changes in that Act are made by Congress, notices will be sent to all taxpayers by collectors of internal revenue with instructions as to the new procedure and for the information of members of the State Association such changes, if any, will be analyzed in *The Journal* at a later date.

Failure to receive a blank does not relieve a physician of the responsibility to file a return on or before March 15, 1934. If blanks are not received by a physician who is required to file a return, he should apply at the internal revenue office of the district in which he resides. These districts, with the name and address of collectors, are appended to this article.

Some of the high points of the Revenue Act of 1932, the present basis for making income tax returns for the calendar year 1933, are:

(1) Normal tax rate, 4 per cent of the first $4000 in excess of exemptions and credits; 8 per cent on the remainder of such excess.

(2) Personal exemptions, which are credits against net income for the purpose of computing the normal tax but not the surtax, of $2500 if married and living with wife, or if the head of a family; $1000 if single and not the head of a family; $400 credit for each dependent under 18 years of age or physically or mentally handicapped dependent.

(3) No earned income credit, meaning that all taxable income whether earned or income from other sources, is subject to the same rate of taxation.

(4) Surtax rates to apply to all net incomes in excess of $6000.

(5) Drastic limitation of losses on the sale or exchange of stocks and bonds held for two years or less.

Following is a detailed analysis of the procedure physicians should follow in filling out blanks for their 1933 income and an example of how computations should be made:

Every physician whose net income for 1933 was $1000 or more, if single, and $2500 or more, if married or the head of a family, must file an income tax return with the Collector of Internal Revenue of his district on or before March 15, 1934. He also must file a return if his gross income was $5000 or more, irrespective of marital status and irrespective of net income.

All physicans and other professional men are required to use Form 1040 in submitting their return, regardless of the amount of net income. All groups, joint ventures and other incorporated organizations are regarded as partnerships and must file partnership information returns, the members of such groups to report their distributive shares as their own income.

GROSS INCOME

Gross income includes gains made from professional services, business activities, certain forms of dividends and interest, bad debts charged off in previous years but since collected, bonuses received as compensation, partnership profits, profits from the sale or exchange of real estate, rents and royalties, and funds received from other sources.

PERSONAL EXEMPTIONS

If married and living with wife, or the head of a family, for the entire year, an exemption of $2500 is allowed; if single and not a head of a family, an exemption of $1000 is permitted. Credit of $400 is permitted for each dependent under 18 years of age or each physically or mentally handicapped dependent regardless of age. The credit is not allowed in the case of a dependent minor over 18 years of age, even if such minor is attending school. In case of a change during the calendar year of the status of the physician in so far as it effects the personal exemption or credit for dependents, the personal exemption and credit should be apportioned in accordance with the number of months before and after such change. Authority for prescribing rules and regulations for such apportionment is given to the Commissioner of Internal Revenue.

ITEMS NOT REPORTABLE AS INCOME

The following items should not be included in gross income since they are exempt to income tax:

Cash or value of property acquired by gift, bequest or inheritance (income from such property is taxable, however); insurance proceeds; damages received in personal actions; dividends on stock of Federal Reserve Banks, land banks, and intermediate credit banks; dividends from corporate earning accumulated prior to March 1, 1913; state jury court fees; state court receivership fees; stock dividends and rights; interest received

from the obligations of state or political subsivisions thereof; interest from securities issued under the Farm Loan Act; interest on Liberty 3½ per cent Bonds and U. S. Bonds issued prior to September 1, 1917, and interest on the obligations of the possessions of the United States.

Interest received on Liberty 4 per cent and 4½ per cent Bonds and certain other U. S. obligatoins is exempt if the total holdings are not in excess of $5000. Interest received from U. S. Treasury Notes *is reportable* as income. However, interest from these sources is subject only to surtax since it is deductible as credit from gross income in computing net income.

Allowances received under the provisions of the War Risk Insurance, Vocational Rehabilitation and World War Veterans' acts, and pensions received from a State or the United States are not exempt from income tax.

DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted from gross income:

Office Rental—If a physician pays rent to another person for office space, he may deduct the amount. However, if he owns his own home and maintains an office in it, he *cannot* claim deduction for office rent.

Automobile—The cost of repair and upkeep of an automobile used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes.

If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes.

In other words, if an automobile is used only partly for business purpose, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs are exempt and may be deducted. Expenses incurred in taking graduate courses have been held *not* to be deductible.

Traveling Expenses—Traveling expenses incurred by a physician in attending medical conventions of organizations of which he is a member are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries of nurses, laboratory workers, technicians, assistants, stenographers or other clerical workers in a physician's office so long as their duties are connected with professional work. Wages paid maids for services rendered in connection with professional practice also are deductible.

Medicines, Instruments, Etc.—Cost of medicines, used in the office to treat patients, medicine dispensed, bandages, laboratory materials and all other supplies necessary to operate the office may be deducted. One-fifth of the purchase price of surgical instruments may be deducted annually for five years under a depreciation account. All office fixtures, appliances, etc., used in office or laboratory may be depreciated annually, according to the estimated life of their usefulness. The customary depreciation for office fixtures and furnishings is 10 per cent annually.

General Office Expense—The cost of telephone, telegrams, etc., used in professional services may be deducted. Expenditures for heat, light, water, etc., in the office are deductible.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursement" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician must be careful, however, to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All license fees which physicians are required to pay are deductible items. This includes the narcotic tax, automobile license, local occupational taxes, taxes on club dues, etc. All taxes paid upon real or personal property, whether the property is used for business or otherwise and all interest paid upon indebtedness (except interest paid to carry nontaxable securities) are deductible. The Ohio Gasoline Tax has been held as *not* deductible.

Federal taxes upon checks, electrical energy, safety deposit box rentals, and use of communication facilities are deductible.

Losses by Fire and Theft—Loss of and damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business ex-

pense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair claimed as a deduction.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are *not* deductible, nor is interest on indebtedness incurred in connection with the purchase or carrying of annuities.

Legal Expense—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is *not* deductible.

Contributions—It is permissible to deduct from gross income contributoins when made to charitable, religious, educational and scientific organizations, to an amount not to exceed 15 per cent of the net income, exclusive of such contributions.

NORMAL TAX RATE

As explained previously, the normal tax rate on 1933 income is 4 per cent on the first $4000 in excess of exemptions and credits and 8 per cent on the remainder of such excess.

SURTAX RATES

In addition to the normal tax as computed above, a surtax is levied upon net income as follows:

First $6,000, no tax; $6,000 to $10,000, 1%; $10,000 to $12,000, 2%; $12,000 to $14,000, 3%; $14,000 to $16,000, 4%; $16,000 to $18,000, 5%; $18,000 to $20,000, 6%; $20,000 to $22,000, 8%; $22,000 to $24,000, 9%; $25,00 to $26,000, 10%; $26,000 to $28,000, 11%; $28,000 to $30,000, 12%; $30 000 to $32,000, 13%; $32,000 to $36,000, 15%; and an additional 1% surtax on each $2,000 increase in net incomes up to $1000,000. Net incomes between $100,000 and $150,000 are surtaxed at 48%; those from $150,000 to $200,000 at 49%; $200,000 to $300,000, 50%: $300,000 to $400,000, 51%; $400 000 to $500,000, 52%; $500,000 to $750,000, 53%; $750,000 to $1,000,000, 54%, and more than $1,000,000, 55%.

HOW COMPUTATIONS ARE MADE

An example of how computations are made is given here for the information of physicians. Although the figures used in the following tabulation may appear to be out of proportion to the actual income of the average physician during the past year, they are used for the purpose of showing how the normal and surtax rates should be applied in case a physician's taxable income should amount to more than that subject to normal income tax.

Suppose a married physician with no dependents and who rents his home and office, had a gross income during 1933 of $20,000 and ordinary expenses. He would submit the following data in his return and compute his tax as follows:

Gross Income

Income from professional services	$15,000.00	
Income from other sources:		
Rent from apartment house	4,000.00	
Taxable interest and dividends	1,000.00	
Total gross income		$20,000.00

Expenses, Credits, Etc

Depreciatoin of office fixtures, etc.	$ 400.00	
Office help, etc.	1,500.00	
Telephone, heat. light, etc.	400.00	
Auto cost and depreciaton	800.00	
Drugs, bandages, medicine, etc.	2,500.00	
Dues, insurance, etc	300.00	
Traveling expenses to medical conventions	200.00	
Office rent	1,000.00	
Taxes on apartment, overhead, etc.	2,600.00	
Interest on mortgage, etc.	200 00	
Miscellaneous expense	100.00	
Total expenses		$10,000.00
Net income (gross income less total expenses)		10,000.00
Personal exemption		2,500.00
Income subject to normal tax		$ 7,500.00

Computation of Normal Tax and Surtax

Taxable at 4% ($4,000)	$160.00	
Taxable at 8% (3,500)	280.00	
Surtax on net in excess of $6,000 to $10,000 at 1%	40.00	
Total normal tax and surtax		$ 480.00

DISTRICRS AND COLLECTORS

Any physician failing to receive an income tax blank should apply to the Collector of Internal Revenue for his district. These districts, together with the name and address of the Collector, and counties comprising such districts follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue Harry F. Busey, Postoffice Building, Third and State Sts., Columbus, Ohio; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue Carl E. Moore, 262 Federal Building, Cleveland, Ohio; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Mon-

roe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue Thomas J. Connor, Custom Building, Cincinnati, Ohio; comprising the following counties:

Brown, Butler, Clarke, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue Charles H. Graves, Toledo, Ohio; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

State Personal Property Tax Returns Due Between February 15 and March 31

Ohio physicians should remember that returns under the Ohio Personal Property Tax Law should be made between February 15 and March 31. All tangible and intangible personal property in possession of a physician on January 1, 1934, which is subject to taxation under the Ohio law should be listed on the return and filed with the county auditor between those dates. Such returns should be made in duplicate. The statute is intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any requirements of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accouuts receivable.

As defined in Section 5327 of the law, credits "means the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts includes items receivable or payable on demand or within one year from the date of inception, however evidenced".

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the ACTUAL VALUE of his current accounts receivable—the amount that can probably be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1934 return he would be permitted to return as of "no value" accounts receivable which he listed in 1933 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1933 but which have decreased in actual value during the past year.

THE State Headquarters Office of the State Association is now located at 1005 Hartman Theater Building, 79 East State Street, Columbus.

Members communicating with the headquarters office should use this new address to insure prompt delivery of letters or telegrams.

Just as a reminder, the attention of the membership is called to the fact that in compliance with postal regulations the names of all unpaid members must be removed from *The Journal* mailing list after the March, 1934, issue. Members who are still delinquent with their 1934 membership dues should transmit them immediately to the secretary-treasurer of their county medical society or academy of medicine. Prompt payment of dues will insure the continuance of *The Journal*, as well as other organization benefits.

Building Prospects at State Hospitals

A plan to end the overcrowded conditions existing at the state's mental hygiene institutions has been launched by Governor George White and the State Department of Public Welfare.

The administration's program calls for the expenditure of approximately $3,000,000 for the expansion of facilities at the various institutions.

The Public Works Administration will be asked to provide 30 per cent of this amount, or $900,000, and the Ohio General Assembly will be called upon to appropriate the remainder, or $2,100,000, from the general revenue fund of the state during the next five years from money paid into the state treasury for the support of patients in the mental hygiene institutions.

The tentative program calls for the following expenditures: Hawthornden Farm, Cleveland, $585,000; Athens State Hospital, $376,000; Dayton State Hospital, $400,000; Girls' Industrial School, Delaware, $235,000; Longview State Hospital, Cincinnati. $425,000; Institution for Feeble Minded, Apple Creek, $750,000, and Toledo State Hospital, $225,000.

Wapakoneta—Dr. Roy C. Hunter has been elected commander of Wapakoneta Camp, No. 22, United Spanish War Veterans.

CLEVELAND GROUP HOSPITAL PAYMENT PLAN GAINS IMPETUS THROUGH ACADEMY ACTION

Approval of a hospital insurance payment plan proposed by the Cleveland Hospital Council whereby hospital services will be provided by a group of Cleveland hospitals participating in the plan to groups of employes on an insurance basis has been voted by the Council and Board of Directors of the Cleveland Academy of Medicine.

The original Cleveland hospital insurance plan, several provisions of which were analyzed in the November, 1933, issue of *The Journal*, pages 714-717, provided a maximum of three weeks' hospital service in one year at insurance rates of $9.00 or $7.20 per year, depending upon the type of accommodation desired. The same rates are retained in the revised plan approved by the Cleveland Academy official boards.

In connection with the general question of hospital insurance payments, attention is called to the action of the Council of the State Medical Association in its definition of qualifications, limitations and safeguards, published on page 777 of the December, 1933, *Journal*.

Action of the Council and Board of Directors of the Cleveland Academy in approving the Cleveland Hospital Council plan is embodied in the following resolution adopted on January 10, at the regular meeting of the Council and Board:

"WHEREAS, The hospitals of Cleveland comprising the Cleveland Hospital Council have developed a plan of group payment for hospital care which includes as essentials of the plan the free choice of hospital by the patient and doctor; the free choice of physician by the patient; the distinct separation of attending physicians' fees from hospital charges; the maintenance of quality of professional services to hospital patients, all of which are not and are not to be changed from present existing customs, and,

"WHEREAS, This plan of group hospitalization is not to be established or operated by any insurance company or other organization or individual for profit, but is to be promoted and operated by a non-profit corporation over which the participating hospitals virtually have control, and,

"WHEREAS, In the formulation of such a plan the Hospital Council has consulted the Academy of Medicine in respect to all the provisions of such a plan relating to the professional services rendered to subscribers under the plan and has earnestly tried to fully protect the interests of the medical profession in the operation of the plan, and

"WHEREAS, The Hospital Council has this day presented to the Academy of Medicine a detailed prospectus of its proposed contract with subscribers, all fully setting forth in detail the mentioned features and has asked the approval of the Academy of Medicine to the prospectus and draft submitted.

"NOW, THEREFORE, BE IT RESOLVED THAT the Academy of Medicine of Cleveland and Cuyahoga County Medical Society appreciates the efforts which the Hospital Council of Cleveland has made to meet the objections to the general plan of group hospitalization held by organized medicine on ethical and economic grounds and believes that these efforts have been successful, and be it,

"RESOLVED THAT the wide acceptance and successful operation of the plan as submitted would be beneficial to the community at large, the hospitals and the medical profession, and be it finally,

"RESOLVED THAT so long as the principles and practices set forth in the prospectus and draft submitted this day are maintained the Academy of Medicine approves and endorses the plan and will cooperate toward its successful operation."

A statement issued by Dr. A. A. Jenkins, newly-installed president of the Cleveland Academy, who presided at the meeting at which the hospital insurance plan was approved, amplified the views of the Council and Board of Directors of the Academy on the Hospital Council's plan.

Commenting on the plan and the action of the Academy's officials, Dr. Jenkins said in part:

"The attitude of organized medicine toward insurance plans having to do with medical services or health is well known. Opposition has been raised and will continue to be raised to any plans which attempt to interject a third party between the physician and his patient or which submit the medical profession to conditions which make it impossible for the profession to serve the public adequately and to maintain its scientific and economic independence or which interfere with the free choice of physicians by patients.

"The plan of the Hospital Council as proposed to us amply safeguards the patient and the profession against any of the interferences which are inherent in so many other insurance plans. It will not change the practice of medicine as it relates to the hospitals and will not substitute hospital practice of medicine for private practice of medicine, since the plan covers only hospital bed care as considered separate and apart from the service rendered by the physician. The medical profession should welcome this plan since it will insure that a large percentage of the populace will not find it necessary to delay payment of physicians for their services because they have to meet a large hospital bill at the time of illness.

"The major hospitals of Cleveland join together to present to the public an insurance plan of payment for hospital services which always necessarily bulk large in comparison with the limited income of certain groups. By joining together, the hospitals unitedly serve the community and obviate the adoption in Cleveland of small parallel competing insurance plans which bring about price-cutting and service-cutting chaos. Cleveland has always been willing to meet its problems with a unified community front. This plan proposed exactly that method of attack on the problem of distribution of hospital costs. The

hospitals in adopting the plan have taken into consideration the possible effects of such a plan upon the medical profession and have amended and outlined the plan to preserve the present adequate and essential elements of private practice as they relate to hospital practice.

"The Academy of Medicine as a branch of organized medicine last year approved the Minority Report of the Committee on the Costs of Medical Care which called for the maintenance of private practice of medicine and re-emphasized the principles which are promulgated in our resolution. The Minority Report further re-emphasized that the medical profession in consultation with existing groups in the local communities should develop plans for providing health services to all classes of people in accordance with their ability to pay. The action of the Board and the Council of the Academy consistently follows the suggestions of the Minority Report of the Committee on the Costs of Medical Care".

Developments in the promotion of group hospitalization in Cleveland undoubtedly will be watched with much interest by hospital officials and the medical profession in other communities, especially as to how well the plan succeeds in the matter of keeping professional and hospital services distinct and separate, one of the basic principles laid down in the Minority Report of the Committee on the Costs of Medical Care.

MEDICAL COLLEGE, OHIO STATE UNIVERSITY, PLANS FOR ELABORATE CENTENNIAL CELEBRATION, MARCH 1, 2 AND 3

Addresses and clinics by some of the nation's leading medical men, a tentative plan for awarding of honorary degrees to distinguished alumni, an exhibit of medical and dental equipment used in Ohio during the past century, class reunions, and convocations of interest to both laymen and physicians are some of the features of the program which has been arranged for the Centennial Celebration of the College of Medicine, Ohio State University, to be held Thursday, Friday and Saturday, March 1, 2 and 3, on the Ohio State University campus.

The college of medicine traces its history back to Willoughby Medical College, established at Willoughby, Ohio, in 1834.

First of the centennial events will be clinics in medicine and surgery to start at 10 a.m., Thursday, March 1, in University Hospital. A clinico-pathological conference will occur there at 2 p.m., followed by an optional dinner at 6:15 p.m. the Faculty Club.

Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, will preside at the night meeting at 8:15 o'clock in University Chapel, where the following addresses will be heard: "The History of Medical Education", by Dr. Francis Packard, editor, *Annals of Medical History*, Philadelphia; "The History of the College of Medicine", Dr. Jonathan Forman, editor, *Phi Rho Sigma Journal*, Columbus; "The Place of Medical Education in the State University", Dr. George W. Rightmire, president, Ohio State University.

President Rightmire will preside at the Friday morning convocation when it is hoped to award honorary degrees to three distinguished alumni, and an address on "The Challenge of the Future" will be presented by Dr. Henry S. Houghton, associate dean, biological sciences, Chicago University. Luncheons and class reunions will occupy the noon hour.

For the afternoon of Friday, March 2, the committee has arranged addresses by Dr. Francis C. Wood, editor, *American Journal of Cancer*, Crocker Foundation, New York, and Dr. Edward Francis, of the United States Public Health Service, Washington, D. C. Dr. Wood will discuss "Cancer". Dr. Francis' subject is "Tularemia".

On Friday night, banquets for alumni will be held by these Ohio State medical fraternities: Phi Rho Sigma, Phi Chi, Alpha Kappa Kappa, Alpha Mu Pi Omega, Phi Delta Epsilon, Theta Kappa Psi, and Alpha Epsilon Iota.

One of the events of Saturday morning, March 3, will be an address on "Metabolism in Medicine", by Dr. William S. McCann, chairman of the department of medicine and director of Strong Memorial Hospital, Rochester, N. Y.

Surgical clinics will be conducted Saturday morning by Dr. L. C. Gatewood, associate professor of surgery, Rush Medical College, Chicago; Dr. Mont Reid, chairman, department of surgery, University of Cincinnati; and Dr. Roy D. McClure, surgeon-in-chief, Henry Ford Hospital, Detroit. At the same time medical clinics will be conducted by Dr. F. A. Hartman, professor of physiology, University of Buffalo, N. Y.; and Dr. Torald H. Sollman, dean, college of medicine, Western Reserve University, Cleveland.

Another Saturday morning event will be medical and surgical groups, and a discussion of "Irradiation Therapy", by Dr. George T. Pack, Memorial Hospital, New York.

After a luncheon in University Hospital for alumni and guests, additional clinics will be held by Dr. Robert Zollinger, Peter Brent Brigham

Hospital, Boston; Dr. R. A. Moore, associate professor of pathology, Cornell Medical Center, New York; Dr. Raymond L. Pfeiffer, Institute of Opthalmology, and Dr. Samuel T. Mercer, research fellow, department of dermatology, Columbia Medical Center, New York.

An Alpha Omega Alpha initiation and supper will occur in the Faculty Club, Saturday, March 3, at 6 p.m., to be followed by the first annual Alpha Omega Alpha public address in Campbell Hall, at 8 p.m. Dr. Charles Emerson, former dean of the medical college, Indiana University, Bloomington, Ind., will be the speaker.

Members of the general committee arranging for the centennial are Dr. Ernest Scott, chairman; Dean J. H. J. Upham, Dr. Charles A. Doan, Dr. Verne Dodd, Dr. Jonathan Forman, John B. Fullen, and Harold K. Schellenger.

All meetings are open to the public, with the Thursday night, Friday morning, Friday afternoon, and Saturday night sessions being arranged for laymen as well as members of the medical profession. No charge will be made for any of the sessions, other than for the luncheon and dinner events.

In connection with its anniversary program, the college is arranging an exhibit of medical and dental equipment, including instruments, books, and office furnishings used in Ohio during the past century. It is particularly desirous to secure such articles in use prior to 1850 and members of the profession are invited to loan any such materials they may have.

The present Medical College of Ohio State University is the result of mergers and consolidations which have brought together Willoughby founded in 1834; Starling Medical College dating from 1848; Columbus Medical College founded in 1875; Ohio Medical University established in 1892; and Starling-Ohio Medical College, dating from 1907. Starling-Ohio was the immediate predecessor of the present college.

In commemoration of the Centennial Celebration a One Hundred Year Book will be published under the auspices of the medical college faculty and the alumni committee on arrangements. Subscriptions of $10.00 for the publication which will be a narrative and pictorial history of the college are now being received by the college.

The Cleveland Medical Library Association is planning an exhibit of monaural stethoscopes for the A. M. A. meeting in June. From time to time a considerable number of unusual specimens have been deposited in the museum and now form a very creditable display. Additional material, however, would be appreciated as a loan or more preferably, as a gift. Anyone wishing to cooperate may send stethoscopes to Dr. Howard Dittrick, Curator of the Museum, Cleveland Medical Library Association.

NEWS NOTES of OHIO

Oberlin—Dr. R. W. Bradshaw, director of the student health service, Oberlin College, was elected president of the American Student Health Association at the recent meeting of the association in Chicago.

Defiance—Dr. R. B. Cameron, veteran Defiance physician and county health commissioner, recently celebrate his 88th birthday.

Troy—Agreement has been reached by the county commissioners and the Miami County Medical Society for the care of needy cases of tuberculosis financed by county funds in private homes instead of having such cases sent to tuberculosis sanitoria.

Cincinnati—Dr. William Wenning, for the past 50 years a member of the Cincinnati Obstetrical Society, was the guest of honor at the recent annual fellowship dinner of the society.

Cleveland—Announcement has been made of the marriage of Miss Mildred Mlazovsky and Dr. Joseph A. Bodnar.

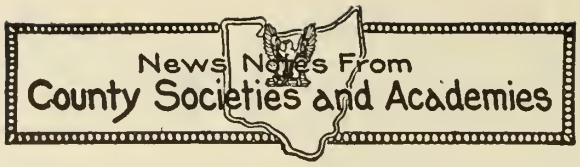
Cleveland—Dr. Howard T. Karsner, professor and director of the Institute of Pathology, Western Reserve University, delivered the Smith-Reed-Russell Lecture at the School of Medicine, George Washington University, Washington, recently. He spoke on "Rheumatic Heart Disease".

Cincinnati—Dr. Mont R. Reid, professor of surgery, University of Cincinnati, has been awarded the Matas Medal by Tulane University for his work in vascular surgery.

Columbus—Dr. T. N. Manos, formerly an intern at White Cross Hospital, this city, has opened offices at 188 E. State Street, Columbus.

Columbus—A fellowship created at the Ohio State University, College of Medicine, by the National Research Council, has been awarded to Dr. Carl V. Moore, formerly of St. Louis, who will do research work in the physiology of red cell production and function of bone marrow as an approach to a better understanding of the anemias.

Cincinnati—Dr. L. Howard Schriver has been elected president of the Cincinnati Public Health Federation for 1934. Other officers elected were: First vice president, Dr. Richard S. Austin; second vice president, Dr. Walter List; honorary secretary, Dr. Julien E. Benjamin; treasurer, Harry M. Shoemaker. Included among the members-at-large of the governing board are: Drs. A. C. Bachmeyer, Elizabeth Campbell, Albert H. Freiberg, Otto P. Geier, J. Victor Greenebaum, A. Graeme Mitchell, William Muhlberg, C. A. Neal, T. A. Ratliff, I. M. Rubinow and Derrick T. Vail, Jr.



First District

ACADEMY OF MEDICINE OF CINCINNATI
(Harold F. Downing, M.D., Secretary)

January 8—General Session. Program: "Iodine Metabolism in Toxic Goiter", Dr. George M. Curtis, Columbus, professor of surgery, Ohio State University.

January 15—General Session. Program: "Criteria for Evaluating Compounds Employed in the Treatment of Syphilis and the Amount to be Given", Dr. John A. Kolmer, professor of medicine, Temple University, Philadelphia.

January 22—General Session. Consideration of the report of a special committee, headed by Dr. Albert H. Freiberg, to study the majority and minority reports of the Committee on the Costs of Medical Care.

January 29—General Session. Program: "Some Practical Considerations of Sinus Disease", Dr. Edward King; discussion by Dr. Joseph Ganim and Dr. H. H. Vail; "Cancer of the Breast", Dr. Otto J. Seibert; discussion by Dr. Charles Goosmann; "A New Approach to the Diagnosis and Therapy of Whooping Cough", Dr. Salmen K. Siebler; discussion by Dr. Samuel Okrent and Dr. Stanley E. Dorst.

Adams County Medical Society met December 13 at West Union. Preceding the meeting a tonsil clinic was held, in charge of Dr. A. R. Quigley, Maysville, Kentucky. The meeting was devoted largely to a discussion of medical poor relief and periodic health examinations.—News Clipping.

Butler County Medical Society in session December 21 at Mercy Hospital, Hamilton, elected the following officers for 1934: President, Dr. H. A. Moore, Oxford; vice president, Dr. W. T. Stewart, Oxford; secretary-treasurer, Dr. V. E. Roden, Hamilton; legislative committeeman, Dr. E. T. Storer, Middletown; medical defense committeeman, Dr. H. M. Lowell, Hamilton; delegate, Dr. M. O. Cook, Hamilton; alternate, Dr. W. E. Griffith, Hamilton. After the business session, Dr. Mark Millikin, Hamilton, spoke on "Present Day Economic Problems of the Doctor".—V. E. Roden, M.D., Secretary.

Clinton County Medical Society has elected officers as follows for the ensuing year: President, Dr. H. E. Gibson, Blanchester; vice president, Dr. Gaylord Anderson, Fayetteville; secretary-treasurer, Dr. E. W. Peelle, Wilmington; delegate, Dr. Elizabeth Shrieves, Wilmington; alternate, Dr. F. A. Peelle, Wilmington; medical defense committeeman, Dr. C. A. Tribbett, Westboro; legislative committeeman, Dr. E. Briggs, Wilmington; censors, Dr. C. E. Kinzel, Wilmington; Dr. L. H. Fullerton, New Vienna, and Dr. W. B. Yoakley, Wilmington.

At its regular meeting on January 3, the society was addressed by Dr. Parke G. Smith, Cincinnati, councilor of the First District, and Dr. Joseph M. Ganim, Cincinnati. Dr. Smith discussed "Medical Economics". Dr. Ganim presented a paper on "Laboratory Procedures for the General Practitioner".—E. W. Peelle, M.D., Secretary.

Highland County Medical Society held its annual dinner meeting and election of officers on December 6 at Hillsboro. The guest speaker was Dr. John A. Caldwell, Cincinnati, president-elect of the State Association, who discussed "Appendicitis". The following officers were elected: President, Dr. T. W. Roberds, Belfast; vice president, Dr. H. W. Chaney, Sugar Tree Ridge; secretary-treasurer, Dr. W. B. Roads, Hillsboro; legislative and medical defense committeeman, Dr. J. C. Larkin, Hillsboro; delegate, Dr. Larkin, alternate, Dr. W. H. Wilson, Greenfield.

At its meeting on January 3, the society was addressed by Dr. J. W. Means and Dr. G. I. Nelson, both of Columbus, Dr. Means discussed "Breast Conditions" and Dr. Nelson, "Heart Lesions".—W. B. Roads, M.D., secretary.

Second District

Champaign County Medical Society in session December 6 installed Dr. J. D. O'Gara, Urbana, as president for the ensuing year and elected the following other officers: President-elect, Dr. Mark Houston, Urbana; secretary-treasurer, Dr. L. A. Woodburn, Urbana; legislative committeeman, Dr. D. C. Houser, Urbana; medical defense Committeeman, Dr. N. M. Rhodes, Urbana; delegate, Dr. D. C. Houser; alternate, Dr. J. W. Norman, St. Paris. A medical economics committee composed of the president, president-elect, and secretary was authorized. Dr. Lewis Inskeep, Urbana, was named to serve on the hospital committee with Dr. Robert V. Anderson, North Lewisburg, and Dr. Richard Henderson, Urbana.—L. A. Woodburn, M.D., secretary.

Clark County Medical Society elected Dr. E. Paul Greenawalt, Springfield, president for the ensuing year at its meeting on December 27. Other officers elected are: Vice president, Dr. J. Roger Marquart, Springfield; secretary, Dr. Roy D. Arn, Springfield; treasurer, Dr. F. P. Anzinger; delegate, Dr. D. W. Hogue. After the business meeting, a paper was read by Dr. Anzinger on "Clinical Blood Pressure".—News Clipping.

Darke County Medical Society had as its guest

speaker on December 15, Dr. W. C. Breidenbach, Dayton, who addressed the society on "A Review of Collapse Therapy in the Treatment of Pulmonary Tuberculosis". At the business session, officers for 1934 were elected as follows: President, Dr. B. F. Metcalf, Greenville; vice president, Dr. J. W. VanLue, Gettysburg; secretary-treasurer, Dr. W. D. Bishop, Greenville; legislative committeeman, Dr. J. E. Hunter, Greenville; medical defense committeeman, Dr. O. P. Wolverton, Greenville; delegate, Dr. C. I. Stephen, Ansonia; alternate, Dr. J. E. Gillette, Versailles.—W. D. Bishop, M.D., secretary.

Miami and Shelby Counties—Annual joint meeting of the Miami and Shelby County Medical Societies was held at the Favorite Hotel, Piqua, January 5, with the Miami County Society as host. The guest speaker was Dr. A. C. Bachmeyer, dean of the College of Medicine, University of Cincinnati, who discussed "Medical Economics". Following the program a dinner was served and a social hour enjoyed.—Bulletin.

Montgomery County Medical Society in session January 5 addressed by Dr. Albert F. Kuhl and Dr. L. G. Bowers on "The Acute Abdomen". Discussants were Dr. Bowers and Dr. Curtis Ginn.

At its January 19 meeting, the society was addressed by D. P. Snyder, D.D.S., Columbus, on "The Responsibility of the Dentist in Phases of Surgery in the Oral Cavity".—News Clipping.

Preble County Medical Society at its regular meeting December 21 at Seven Mile Tavern, Eaton, was addressed by Dr. F. I. Shroyer, Dayton. Dr. Shroyer discussed "Diagnosis and Treatment of Gynecological Conditions in Everyday Practice".—News Clipping.

Third District

Allen County—The Academy of Medicine of Lima and Allen County has elected the following officers for the ensuing year: President, Dr. J. R. Johnson, Lima; vice president, Dr. Walter Noble, Lima; secretary, Dr. K. L. Parent, Lima; treasurer, Dr. J. B. Poling, Lima; legislative committeemen, Dr. William Roush and Dr. A. N. Wisely; medical defense committeeman, Dr. R. A. Buchanan, Lima; delegate, Dr. Ezra Burnett; alternate, Dr. W. A. Noble.—News Clipping.

Auglaize County Medical Society met in regular bi-monthly session December 14 at Wapakoneta with 20 members present. Dr. R. O. Ruch, Lima, preesnted an interesting series of lantern views on "Common Skin Diseases," with an appropriate description of the treatment for each. Dr. J. R. Tillotson, Lima, discussed "Fractures of the Femur", indicating the proper handling of the different varieties of fractures of the thigh and hip. At the business session, the following officers were elected for 1934: President, Dr. E. F. Heffner, Wapakoneta; vice president, Dr. H. J. Gudenkauf, Minster; secretary-treasurer, Dr. C. C. Berlin, Wapakoneta; delegate, Dr. Guy E. Noble, St. Marys; alternate, Dr. Roy C. Hunter, Wapakoneta; censor, Dr. F. F. Fledderjohann, New Bremen.—C. C. Berlin, M.D., secretary.

Hancock County Medical Society met in regular session January 4 at the Elks' Club, Findlay. Dr. A. A. Tombaugh, formerly of McComb, now of McConnelsville, gave an interesting paper on "Early Diagnosis of Incipient Tuberculosis". A general discussion followed.—H. O. Crosby, M.D., secretary.

Hardin County Medical Society at its regular meeting December 21 at Kenton elected the following officers for the ensuing year: President, Dr. F. M. Elliott, Ada; vice president, Dr. C. R. Blosser, Dunkirk; secretary-treasurer, Dr. W. N. Mundy, Forest; legislative committeeman, Dr. E. S. Protzman, Kenton; medical defense committeeman, Dr. R. G. Schutte, Kenton; delegate, Dr. Don P. Printz, Ada; alternate, Dr. C. R. Blosser, Dunkirk. The program was presented by Professors C. H. Freeman and H. E. Huber, Ohio Northern University, Ada.—W. N. Mundy, M.D., secretary.

Logan County Medical Society was addressed by Dr. Charles A. Doan, Columbus, at its meeting December 5 at the Hotel Ingalls, Bellefontaine. Dr. Doan spoke on "Differential Diagnosis and Rational Treatment of Certain Diseases in Which A Low Blood Count is a Prominent Presenting Sign". The following officers were installed: President, Dr. John Maurer, West Liberty; vice president, Dr. C. K. Startzman, Bellefontaine; secretary-treasurer, Dr. Richard A. Firmin, Zanesfield.

On January 5 the society heard four papers on various subjects, presented by Dr. Hobart Mikesell, West Liberty; Dr. John Maurer, West Liberty; Dr. Robert Pratt, Bellefontaine, and Dr. A. J. McCracken, Bellefontaine.—News Clipping.

Marion County—The Academy of Medicine of Marion met in regular session January 2 at the Marion City Hospital. The new officers were installed after the retiring president, Dr. E. L. Brady, had thanked the members for their cooperation during the past year. Dr. H. K. Mouser, the incoming president, outlined his plans for the ensuing year after which there was an enthusiastic discussion of business questions.—J. W. Jolley, M.D., secretary.

Mercer County Medical Society reorganized for the ensuing year on December 28 by electing the following officers: President, Dr. P. W. Fishbaugh, Mendon; vice president, Dr. E. J. Willke, Maria Stein; secretary-treasurer, Dr. Frank E. Ayers, Celina; delegate, Dr. Paul E. Rex, Rockford.—F. E. Ayers, M.D., secretary.

Seneca County Medical Society was addressed by Dr. Norris Gillette, Toledo, at its regular meet-

ing December 21. Dr. Gillette spoke on "Abdominal Surgery in Children".—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

January 5—Annual Meeting of the Academy. Reports of retiring officers. Installation of new president, Dr. M. D. Haag. Election of following officers for the ensuing year: President-elect, Dr. Thomas L. Ramsey; secretary, Dr. A. P. Hancuff; councilor, three-year term, Dr. F. C. Clifford; trustee, Dr. L. R. Effler retiring president.

January 12—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Amoebic Dysentery", Dr. T. A. Owens; Amoebiasis—A Public Health Problem," Dr. James B. Rucker, Jr.

January 19—Medical Section. Program: "Peripheral Vascular Diseases", Dr. J. L. Stifel; "The Pathology of Peripheral Vascular Diseases", Dr. Bernhard Steinberg; "The Surgical Aspect of Peripheral Vascular Diseases", Dr. N. C. Spencer; discussion opened by Dr. A. A. Applebaum.

January 26—Surgical Section. Program: "Vaginal Hysterectomy", Dr. G. H. Reams; "Maternal Mortality", Dr. B. H. Carroll.

Henry County Medical Society has elected the following officers for 1934: President, Dr. B. G. George, Liberty Center; vice president, Dr. C. B. Geiger, Holgate; secretary-treasurer, Dr. F. M. Harrison, Napoleon; legislative committeeman, Dr. H. F. Rohrs, Napoleon; medical defense committeeman, Dr. Thomas Quinn, Napoleon; delegate Dr. Quinn; Alternate, Dr. T. P. Delventhal, Napoleon—F. M. Harrison, M.D., secretary.

Putnam County Medical Society had as its guest speaker on January 2, Dr. Walter Noble, Lima, who spoke on "Eye, Ear, Nose and Throat Problems".—News Clipping.

Sandusky County Medical Society in session December 28 at Fremont elected Dr. C. A. Kingman, Bellevue, president; Dr. F. M. Teeple, Fremont, vice president, and Dr. C. J. Wehr, Bellevue, secretary-treasurer for the ensuing year. The guest speaker was Dr. Norris Gillette, Toledo, who discussed "Abdominal Surgery in Children".—News Clipping.

Wood County Medical Society in session December 21 at Bowling Green elected the following officers for 1934: President, Dr. F. L. Sterling, Bowling Green; vice president, Dr. C. S. Cavett, North Baltimore; secretary-treasurer, Dr. R. N. Whitehead, Bowling Green; correspondent, Dr. E. H. Mercer, Bowling Green; legislative committeeman, Dr. Earl D. Foltz, North Baltimore; medical defense committeeman, Dr. F. V. Boyle, Bowling Green; delegate, Dr. G. C. Aurand, Bowling Green; alternate, Dr. A. A. Babione, Luckey. The guest speaker was Dr. Karl D. Figley, Toledo, who discussed "Some Problems in the Management of the Asthmatic".—R. N. Whitehead, M.D., secretary.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

Officers of the Cleveland Academy of Medicine for the ensuing year are: President, Dr. A. A. Jenkins; vice president, Dr. Lester Taylor; secretary-treasurer, Dr. C. H. Heyman; new members of board of directors, Drs. D. M. Glover, F. S. Gibson, Theodore Miller, H. G. Sloan and Lester Taylor; chairmen of major committees: administration, Dr. Lester Taylor; board of censors, Dr. J. E. Tuckerman; economics, Dr. H. G. Sloan; health education, Dr. H. C. King; legislation, Dr. F. S. Gibson; membership, Dr. John Tucker; milk commission, Dr. J. J. Thomas; program, Dr. R. L. Haden; publication, Dr. Howard Dittrick; public health, Dr. A. G. Cranch; medical defense, Dr. J. E. Tuckerman.

January 5—Clinical and Pathological Section. Program: "A Case of Exopthalmic Goiter", Dr. E. J. Stefanic; "The New Deal for the Prostatic", Dr. W. J. Manning and Dr. J. B. Morgan; "Osteomyelitis of Skull Following Frontal Sinus Infection", Dr. J. T. Collins; "Aneurism of Ventricle Diagnosed During Life", Dr. R. K. Updegraff; "Staphylococcus Hemolyticus Septicemia (Case Report)", Dr. R. J. Schraff and Dr. J. P. Gavan; "Fracture Technique", Dr. G. I. Bauman; "Report of a Case of Carcinoma of the Stomach, Followed by Death Five Years After Resection—Operative and Postmortem Specimens", Dr. D. Foldes and Dr. H. Sneiderman.

January 12—Joint meeting of Experimental Medicine Section and the Cleveland Section of the Society for Experimental Biology and Medicine. Program: "Glutathione Content of Blood", Russell O. Bowman, Ph.D.; "Carotenemia: Its Influence on the Validity of the Icteric Index", Earl F. Nation, A.B., and Victor C. Myers, Ph.D.; "Skin Lesions in Mice Due to Vitamin G Deficiency", Donald G. Remp, B.A. and Franklin C. Bing, Ph.D.; Metabolism of Iron and Copper in Anemic Rats", Franklin C. Bing, Ph.D., Esther M. Saurwein, M.S., and Victor C. Myers, Ph.D.; "Magnitude of the Renal Iron Excretion in Healthy Men," Ramon F. Hanzal, Ph.D. and Franklin C. Bing, Ph.D.; "Studies on Tissue Respiration," Edward Muntwyler, Ph.D.; "Etiology of Whooping Cough," Dr. Gerald Shibley.

January 24—Obstetrical and Gynecological Section. Program: "Pathology of Eclampsia", Dr. Anna M. Young; "The Toxemias of Early Pregnancy", Dr. W. D. Fullerton; "The Toxemias of the Later Months of Pregnancy", Dr. Joseph T. Smith, Jr.

Lake County Medical Society has elected the following officers for the ensuing year: President,

Dr. Burt T. Church, Painesville; vice president, Dr. Lloyd Judd, Painesville; secretary-treasurer, Dr. Mabel Pearce, Painesville; legislative committeeman, Dr. William P. Ellis, Painesville; delegate, Dr. V. N. Marsh, Painesville.—Mabel Pearce, M.D., secretary.

Lorain County Medical Society held its annual election of officers on December 12. The following were elected: President, Dr. George M. Blank, Lorain; vice president, Dr. L. H. Trufant, Oberlin; secretary-treasurer, Dr. W. E. Hart, Elyria; legislative committeeman, Dr. S. V. Burley, Lorain; delegate, Dr. Burley; alternate, Dr. H. C. Stevens, Elyria. The principal speaker was Dr. J. T. Fawcett, Elyria, who discussed "Acute Mastoiditis".

The January meeting of the society was held January 9 with Dr. R. K. Updegraff, Cleveland, as the guest speaker. Dr. Updegraff spoke on "The Electrocardiograph". The discussion was opened by Dr. R. H. McClure, Elyria.—Bulletin.

Trumbull County Medical Society in session December 21 elected the following officers for 1934: President, Dr. J. H. Caldwell, Warren; vice president, Dr. M. T. Knappenberger, Warren; secretary-treasurer, Dr. R. H. McCaughtry, Warren. The guest speaker was Dr. Claude B. Norris, Youngstown, who presented an illustrated lecture on "Syphilis."—News Clipping.

Sixth District

Union Medical Association, comprising the medical societies of the Sixth District, held its 227th session on January 10 at the Massillon State Hospital with a good attendance. The morning program consisted of two papers, "Hallucinations and Diagnosis", by Dr. Arthur O. Gillim, Massillon State Hospital, and "Tumors in Bones", by Dr. P. C. Langan, Akron. Following a luncheon at noon at which those in attendance were guests of the institution, a business session was held and the association was addressed by Dr. C. L. Cummer, Cleveland, president of the Ohio State Medical Association. Dr. Cummer discussed some of the social and economic questions confronting the medical profession and emphasized the necessity for maintaining strong and effective medical organization to protect the interests of the medical profession and the public. The meeting was concluded by presentation of papers by Dr. John D. O'Brien, Canton, and Dr. Arthur Hyde, superintendent of the Massillon State Hospital. Dr. O'Brien discussed "Some Considerations in the Treatment of Neuro-Syphilis", and Dr. Hyde "Nine Years' Experience with Malaria in the Treatment of General Paralysis". The meeting was arranged by Dr. A. E. Brant, Youngstown, president of the association in 1933; Dr. J. H. Seiler, Akron, secretary, and Dr. H. E. Davidson, Akron, councilor of the Sixth District.

Ashland County Medical Society was addressed December 8 by Dr. Jonathan Forman, Columbus, on "Allergic Diseases".—News Clipping.

Holmes County Medical Society has elected Dr. Clyde Bahler, Walnut Creek, president, and Dr. C. T. Bahler, Walnut Creek, secretary, for the ensuing year.

Mahoning County Medical Society at its annual business session, December 19, installed Dr. J. B. Nelson as president and elected the following additional officers for the ensuing year: President-elect, Dr. J. L. Fisher; vice president, Dr. P. J. Fuzy; secretary, Dr. William M. Skipp; treasurer, Dr. Louis Deitchman; correspondent, Dr. B. W. Schaffner; legislative committeeman, Dr. O. J. Walker; medical defense committeeman, Dr. R. E. Whelan; delegates, Dr. L. G. Coe and Dr. Sidney McCurdy; alternates, Dr. Joe Rosenfeld and Dr. W. K. Stewart; censor, Dr. J. P. Harvey. The annual banquet of the society is scheduled for February 1 when Dr. Morris Fischbein, editor of *The Journal of the American Medical Association* will speak.

Portage County Medical Society met in regular session January 4 at the home of Dr. Sivon, Ravenna. Dr. E. H. Knowlton, the new president, was installed. The guest speaker was Dr. M. A. Blankenhorn, Cleveland, who spoke on "Symptom Diagnosis of Gastrointestinal Disease".—Bulletin.

Summit County Medical Society held its annual meeting December 5. Dr. R. G. Werner was installed as president and the following new officers were elected: President-elect, Dr. J. D. Smith; secretary-treasurer, Dr. A. S. McCormick; delegates, Dr. J. G. Blower, Dr. F. C. Potter and Dr. C. R. Steinke; alternates, Dr. J. E. Monnig, Dr. E. R. Stumpf and Dr. J. H. Selby.

Wayne County Medical Society has elected the following officers for 1934: President, Dr. W. A. Morton, Wooster; vice president, Dr. Jean S. Douglas, Wooster; secretary-treasurer, Dr. R. C. Paul, Wooster; legislative committeeman, Dr. N. C. Mayer, Apple Creek; medical defense committeeman, Dr. L. A. Yocum, Wooster.—R. C. Paul, M.D., secretary.

Seventh District

Coshocton County Medical Society held its annual election of officers on December 21. Those elected were: President, Dr. Samuel Kistler, Coshocton; vice president, Dr. W. F. Lyons, Coshocton; secretary-treasurer, Dr. J. D. Lower, Coshocton; legislative committeeman, Dr. E. M. Wright, Coshocton; medical defense committeeman, Dr. D. M. Criswell, Coshocton; delegate, Dr. Samuel Cohen, Coshocton; alternate, Dr. Floyd Craig, Coshocton. Following the business session, Dr. Lyons read a paper on "Progress of Medicine in the Last 50 Years".—J. D. Lower, M.D., secretary.

Jefferson County Medical Society in session December 26 elected the following officers for 1934: President, Dr. George F. Gourley, Steubenville; vice president, Dr. Carl Goehring, Steubenville; secretary-treasurer, Dr. John Y. Bevan, Steuben-

ville; correspondent, Dr. Howard Brettell, Steubenville; legislative committeeman, Dr. A. Jacoby, Steubenville; medical defense committeeman, Dr. A. E. Weinstein, Steubenville; delegate, Dr. S. A. Harris; alternate, Dr. V. B. DiLoreto, Steubenville.—John Y. Bevan, M.D., secretary.

Tuscarawas County Medical Society elected Dr. W. W. H. Curtis, Dennison, president for the ensuing year at its meeting December 14. Other officers elected are: Vice president, Dr. R. D. Hildebrand, Newcomerstown; secretary-treasurer, Dr. Arthur Huston, Jr., Uhrichsville; legislative committeeman, Dr. J. A. McCollam, Uhrichsville; medical defense committeeman, Dr. E. D. Moore, New Philadelphia; delegate, Dr. F. B. Larimore, New Philadelphia.

At its regular meeting January 11, the society was addressed by Dr. R. D. Gill, Wheeling, West Virginia, on "Recent Advances in Treatment of Genito-Urinary Diseases". The discussion was opened by Dr. D. A. MacGregor, Wheeling.—Arthur Huston, Jr., M.D., secretary.

Eighth District

Guernsey County Medical Society in session December 7 elected the following officers for the ensuing year: President, Dr. E. F. Hunter, Cambridge; vice president, Dr. Paul O. Huth, Cambridge; secretary-treasurer, Dr. Reo Swan, Cambridge; correspondent, Dr. O. R. Jones, Cambridge; legislative committeeman, Dr. M. S. Lawrence, Cambridge; delegate, Dr. G. F. Swan, Cambridge; alternate, Dr. W. L. Denny, Cambridge.

On December 21, the society held its annual Christmas party for members, their families and guests at the Cambridge Country Club. A mock trial in which members played the leading roles was the principal entertainment which followed an elaborate turkey dinner. The arrangements were made by Dr. and Mrs. O. R. Jones, Dr. and Mrs. W. L. Denny, and Dr. and Mrs. Harold Neeland.—News Clipping.

Muskingum County—Annual election of officers of the Muskingum County Academy of Medicine was held on December 6 following a banquet at the Zane Hotel. The following were elected: President, Dr. M. A. Loebell, Zanesville; vice president, Dr. R. McDaniel, East Fultonham; secretary-treasurer, Dr. Beatrice T. Hagen, Zanesville; legislative committeeman, Dr. R. S. Martin, Zanesville; medical defense committeeman, Dr. C. M. Rambo, Zanesville; delegate, Dr. M. A. Loebell, Zanesville; alternate, Dr. G. B. Trout, Zanesville.

At its regular meeting January 3, the society was addressed by Dr. R. S. Martin and Dr. W. A. Samuell. Both discussed "Diseases of the Eye". A buffet luncheon was served following the program.—Beatrice T. Hagen, M.D., secretary.

Perry County Medical Society at its annual meeting, December 18, elected the following officers for the ensuing year: President, Dr. James Miller, Corning; vice president, Dr. H. F. Minshull, New Lexington; secretary-treasurer, Dr. F. J. Crosbie, New Lexington; legislative committeeman, Dr. W. D. Porterfield, Junction City; medical defense committeeman, Dr. C. B. McDougal, New Lexington; delegate, Dr. E. D. Allen, Crooksville; alternate, Dr. Harry L. Hite, Thornville.—F. J. Crosbie, M.D., secretary.

Washington County Medical Society elected Dr. W. W. Sauer, Marietta, president at its regular meeting December 13. Other officers elected were: Vice president, Dr. A. H. Whitacre, Chesterhill; secretary-treasurer, Dr. G. M. James, Marietta; legislative committeeman, Dr. A. Howard Smith, Marietta; medical defense committeeman, Dr. J. F. Weber, Marietta; delegate, Dr. R. W. Riggs, Marietta; alternate, Dr. R. M. Meredith, Marietta. The scientific program was presented by Drs. R. C. Peale and Walter R. Griess, both of Cincinnati, who discussed "Avertin As An Anesthetic".—G. M. James, M.D., secretary.

Ninth District

Hocking County Medical Society held its regular December business meeting on December 14 and elected the following officers for 1934: President, Dr. C. C. Lyon, Logan; vice president, Dr. H. M. Boocks, Logan; secretary-treasurer, Dr. M. H. Cherrington, Logan; delegate, Dr. Boocks; alternate, Dr. J. S. Cherrington, Logan; legislative and medical defense committeeman, Dr. J. S. Cherrington; censors, Dr. O. V. Donaldson and Dr. W. B. Lacock; program committee, Dr. M. H. Cherrington, Dr. J. D. Francis, and Dr. Lacock. Following the business session, Dr. M H. Cherrington presented a case report on tularemia.—M. H. Cherrington, M.D., secretary.

Meigs County Medical Society in session December 29 elected officers as follows: President, Dr. Harold M. Crumley, Pomeroy; vice president, Dr. Manning S. Daniels, Pomeroy; secretary-

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treasurer, Dr. Raymond E. Boice, Middleport; delegate, Dr. Boice.—H. M. Crumley, M.D., secretary.

Scioto County—The Hempstead Academy of Medicine held its annual banquet and election of officers on December 11. Officers elected were: President, Dr. Hubert Thurman, Portsmouth; vice president, Dr. George E. Obrist, Portsmouth; secretary-treasurer, Dr. William E. Scaggs; Portsmouth; legislative committeeman, Dr. James S. Rardin, Portsmouth; medical defense committeeman, Dr. A. L. Test, Portsmouth; delegate, Dr. G. R. Micklethwaite, Portsmouth; alternate, Dr. C. M. Fitch, Portsmouth.

At its regular meeting January 8, the academy was addressed by Dr. Max Zinninger, Cincinnati, on "Surgical Tuberculosis of the Chest".—William E. Scaggs, M.D., secretary.

Vinton County Medical Society has elected officers as follows for the ensuing year: President, Dr. O. S. Cox, McArthur; vice president, Dr. H. D. Chamberlain, McArthur; secretary-treasurer, Dr. H. S. James, McArthur; correspondent, Dr. Cox; legislative committeeman, Dr. James; delegate, Dr. A. A. Boal.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)
(George J. Heer, M.D., Secretary Pro Tem.)

January 8—Annual meeting. Installation of the following officers: President, Dr. Verne A. Dodd; vice president, Dr. Roy E. Krigbaum; secretary, Dr. John H. Mitchell; secretary pro tem, Dr. George J. Heer; delegates, Drs. E. J. Emerick, I. B. Harris, J. H. J. Upham, John M. Thomas and J. B. Alcorn; alternates, Drs. E. H. Baxter, George T. Harding, III; H. E. LeFever J. H. Warren and Drew Davies. Program: "Progress in Medicine", Dr. George Nelson; "Progress in Otolaryngology", Dr. E. W. Harris; "Progress in Ophthalmology", Dr. A. D. Frost.

January 15—General Session. Program: "Defective Delinquents", Dr. C. C. Kirk and Dr. A. H. Hopwood, Orient.

January 22—General Practitioners' Section. Program: "Influenza". Paper, "Epidemiology, Symptoms and Treatment", Dr. W. H. Cleveland; Paper, "Complications—Bronchitis and Bronchopneumonia", Dr. L. H. VanBuskirk; Paper, "Nervous Complications, with Special Reference to Encephalitis", Dr. George T. Harding, III, Installation of the following officers: President, Dr. K. H. Armen; secretary, Dr. R. H. Wallace; executive committee, Drs. J. A. Rauschkolb, C. C. Ross and C. H. Wells.

Crawford County Medical Society met in regular session January 8 at the Bucyrus City Hospital. The guest speakers were Dr. Charles W. McGavran and Dr. James H. Warren, Columbus. Dr. McGavran discussed "1934 Diabetic Prob-

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lems", and Dr. Warren "X-ray Diagnosis and Treatment of Colitis".—Bulletin.

Knox County Medical Society has elected the following officers for 1934: President, Dr. E. V. Ackerman, Fredericktown; vice president, Dr. C. L. Harmer, Danville; secretary-treasurer, Dr. Robert L. Eastman, Mt. Vernon; legislative committeeman, Dr. John R. Claypool, Mt. Vernon; delegate, Dr. F. C. Anderson, Mt. Vernon; alternate, Dr. Julius Shamansky, Mt. Vernon.—Robert L. Eastman, M.D., secretary.

Madison County Medical Society in session December 27 at the London Country Club elected the following officers for the ensuing year: President, Dr. R. S. Postle, London; vice president, Dr. W. A. Holman, London; secretary-treasurer, Dr. G. C. Scheetz, West Jefferson; correspondent, Dr. F. E. Rosnagle, London; legislative committeeman, Dr. R. H. Trimble, Mt. Sterling; medical defense committeeman, Dr. Fred Lutz, Mt. Sterling; delegate, Dr. R. W. E. Irwin, Mt. Sterling; alternate, Dr. J. Z. Heston, West Jefferson.—G. C. Scheetz, M.D., secretary.

Pickaway County Medical Society has elected the following officers for 1934: President, Dr. D. V. Courtright, Circleville; vice president, Dr. R. S. Hosler, Ashville; secretary-treasurer, Dr. E. R. Austin, Circleville; delegate, Dr. H. D. Jackson, Circleville; alternate, Dr. Lloyd Jonnes, Circleville.

Ross County Medical Society at its annual meeting elected officers for 1934 as follows: President, Dr. O. P. Tatman, Chillicothe; vice president, Dr. Samuel Sproat, Chillicothe; secretary-treasurer, Dr. W. C. Breth, Chillicothe; legislative committeeman, Dr. H. R. Brown, Chillicothe; medical defense committeeman, Dr. L. T. Franklin, Chillicothe; delegate, Dr. A. E. Merkle, Chillicothe; alternate, Dr. W. B. Smith, Frankfort.—W. C. Breth, M.D., secretary .

An interesting program of lectures and papers was presented during January at the New York Polyclinic Medical School and Hospital, New York City. On January 8, the following program was presented at the meeting of the Clinical Society: "Diverticula of the Colon", Dr. Jerome Morley Lynch, attending proctologist, New York Polyclinic; "Oesophageal Diverticulum: Its Diagnosis, Surgical Management and End Results", Dr. Frank H. Lahey, Boston; "A Plea for the Alexander Method of Shortening the Round Ligaments for Retroversion of the Uterus", Dr. Louis J. Ladin, attending gynecologist, New York Polyclinic. On January 20, a lecture on "The Technique of Version" was given by Dr. Irving W. Potter, consulting obstetrician, New York Polyclinic, on January 24, Dr. Frederick M. Allen, attending physician, New York Polyclinic, spoke on "Diabetes in Children".

—Dr. John Dudley Dunham has been elected chief of staff of Grant Hospital, and Dr. Drew Davies, secretary.

—Dr. D. V. Courtright has been elected chief of staff of Berger Hospital, Circleville; and Dr. E. R. Austin, secretary. The medical advisory board is composed of Drs. E. S. Shane, G. D. Sheets and H. D. Jackson.



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Deaths in Ohio

Edmund M. Baehr, M.D., Cincinnati, University of Cincinnati, College of Medicine, 1901; aged 56; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died January 2 of heart disease. Dr. Baehr was associate professor of physiology at the College of Medicine, University of Cincinnati. He was at one time a member of the State Board of Administration, predecessor to the State Department of Public Welfare, and served on the staff of the State Bureau of Juvenile Research. During the World War, Dr. Baehr was a major in the medical corps. He belonged to the American Psychiatric Association. Surving are his widow and four sisters.

Henry Allen Beck, M.D., Uhrichsville; Jefferson Medical College, 1912; aged 43; died December 25 at the U. S. Veterans' Hospital at Aspinwall, Pa., of disabilities resulting from gas received in military service overseas. Dr. Beck was a native of Tuscarawas County. He had practiced in St. Louis and Dallas, Texas. Surviving are his widow, three sons, two daughters, one brother and two sisters.

Harry L. Beers, M.D., Youngstown; University of Michigan Medical School, 1909; aged 60; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died December 5 following an extended illness. Dr. Beers had practiced in Youngstown for the past 24 years. He was an active member of the Masonic Lodge. Surviving are his widow, two sons, one daughter, one sister and two brothers.

S. E. Boggs, M.D., Washington C. H.; Starling Medical College, 1882; aged 73; member of the Ohio State Medical Association and of the American Medical Association; died December 13 following an extended illness. Dr. Boggs, president of the Fayette County Medical Society during 1933, had practiced in Fayette County for more than 40 years, having practiced at Spencerville, Good Hope and Darbyville before moving to Washington C. H. He was at one time county coroner. His widow, three daughters, one son and one brother survive.

Joseph R. Breitbart, M.D., Cleveland; Cornell University Medical College, Ithaca, N. Y., 1924; aged 33; former member of the Ohio State Medical Association and the American Medical Association; died December 9 at Bermuda where he had gone with the hope of regaining his health. Dr. Breitbart was former head of the allergic department, Mt. Sinai Hospital, Cleveland. His widow, two daughters, his parents, two sisters and one brother survive.

George T. Harding, M.D., Worthington; University of Michigan Medical School, 1900; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died January 18 of a cerebral hemorrhage. Dr. Harding, brother of the late President Harding, was born near Caledonia and educated in the public schools at Marion. After several years of general practice at Marion as an associate of his late father, Dr. George T. Harding, he joined the staff of the Columbus State Hospital, later resigning to become superintendent of a sanitarium at Washington, D. C. He returned to Columbus in 1907 and specialized in the treatment of mental diseases, opening the Columbus Rural Rest Home at Worthington in 1915. Dr. Harding served in the medical corps during the World War and was a psychiatrist for the Veterans' Bureau following the war. He belonged to the American College of Physicians and the American Psychiatric Association. He was a former president of the Columbus Academy of Medicine and a past president of the Columbus Kiwanis Club. Surviving are his widow, three sons, Dr. George T. Harding, III, for the past 13 years his associate; Dr. Warren G. Harding, II, surgeon at a Sydney, Australia, hospital, and Charles W. Harding, student at Otterbein College; two daughters, Ruth, a junior medical student at the College of Medical Evangelists, Los Angeles, and Mary Elizabeth, at home; and three sisters.

Frank R. Harrison, M.D., East Liverpool; University of Pennsylvania, School of Medicine, 1900; aged 54; member of the Ohio State Medical Association and the American Medical Association; died December 3 following a four-months illness. A native of England, Dr. Harrison received his early education in the East Liverpool schools and entered practice here soon after graduation from medical school. He was a member of the Knights of Columbus, Elks Lodge, Lions' Club and American Legion. Surviving are his widow, two sons, three daughters and two brothers.

Charles C. Jones, M.D., Canton; Ohio Medical University, Columbus, 1898; aged 61; died January 5 of cerebral hemorrhage. He had practiced in Canton for 27 years. Dr. Jones belonged to the Elks and Masonic lodges. Surviving are his widow, two daughters, two sons and one brother.

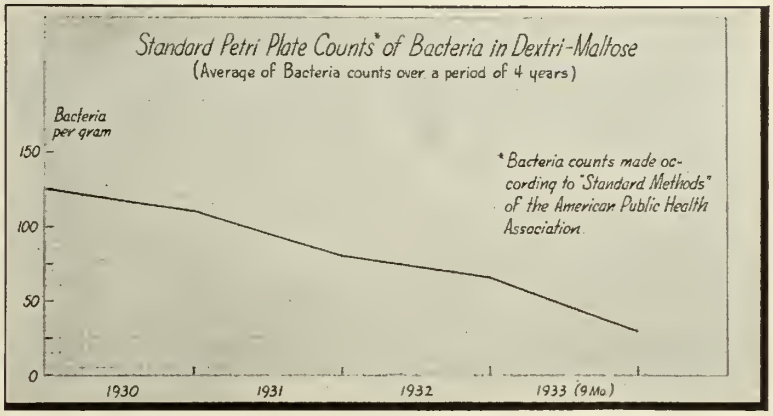
Zedaker V. Luke, M.D., Columbus; Ohio Medical University, Columbus, 1896; aged 67; former member of the Ohio State Medical Association, and American Medical Association; died January 10. Dr. Luke had practiced in Columbus for the past 25 years. He was a member of the Masonic Lodge. Surviving are his widow and one son.

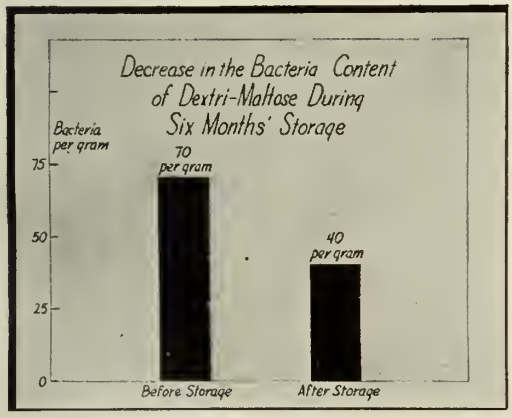
Albert H. McIntyre, M.D., Springfield; Starling Medical College, 1904; aged 63; former member of the Ohio State Medical Association and American Medical Association; died December 21 following an extended illness. He had practiced in

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Springfield since graduating from medical school until a year ago when he retired because of his health. He was a member of the Masonic and Odd Fellows lodges. His widow, one daughter, one sister and one brother survive.

Walter Putnam, M.D., Millersburg; Cleveland College of Physicians and Surgeons, 1887; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died January 5; Dr. Putnam moved to Millersburg from Brinkhaven in 1911. He was a member of the Masonic and Pythian lodges. Surviving are three sons, one of whom is Dr. Isaac Putnam, Dillonvale.

Frank A. Russell, M.D., Kent; Cleveland University of Medicine and Surgery, 1896; aged 59; former member of the Ohio State Medical Association and the American Medical Association; died December 25. Dr. Russell had practiced in Kent for the past 33 years. His widow and one son survive.

Augustus E. Smith, M.D., Warren; Jefferson Medical College, Philadelphia, 1911; aged 54; member of the Ohio State Medical Association and the American Medical Association; died January 4 of heart disease. Dr. Smith is survived by his widow, Dr. Elizabeth Smith, two sons, two daughters, three sisters and two brothers.

Kossuth T. Tinker, M.D., Columbus; Medical College of Ohio, Cincinnati, 1877; aged 78; died December 13. Dr. Tinker had resided in Columbus for the past 20 years, having moved there from Athens, where he had practiced for many years. One son, one brother and one sister survive.

KNOWN IN OHIO

Frank Miranda, M.D., Walkerton, Indiana, formerly of Tippecanoe City; Medical College of Ohio, Cincinnati, 1877; aged 72; died December 25; Dr. Miranda left Tippecanoe City about 35 years ago. One son survives.

Charles F. Eikenberry, M.D., Seattle, Washington, formerly of Eaton; Rush Medical College, Chicago, 1903; aged 57; died December 31. Dr. Eikenberry, a native of Preble County and educated in the Eaton schools, was a member of the American Orthopedic Association; a Fellow of the American Medical Association and a member of the American College of Surgeons. His widow, two daughters, one brother, one sister and one half-brother survive.

—Parker J. McMillin has resigned as superintendent of Cleveland City Hospital to become superintendent of the Baltimore City Hospitals.

—A loan from the Public Works Administration of $335,000 has been obtained by the Huron Road Hospital, Cleveland, for completion of the institution, now two-thirds completed.

HOSPITAL NOTES

—A plan has been worked out between Grant Hospital, Columbus, and officials of Ohio University, Athens, whereby the university will award the B.A. degree to nurses graduating at Grant who have completed a certain amount of required work at the university.

—Plans are underway for building a $500,000 addition to Jewish Hospital, Cincinnati.

—Dr. Leonard Stack has been elected president of St. Joseph's Hospital, Lorain. Other officers are: Vice president, Dr. Russell M. Arnold, Avon Lake, and secretary, Dr. A. J. Kirchner.

—New chief of staff of St. Thomas' Hospital, Akron, is Dr. James G. Kramer. Dr. William A. Parks was elected vice chief. Members of the medical executive board are Dr. Carl R. Steinke, Dr. D. C. Brennan and Dr. Walter A. Hoyt

—Rev. F. E. Strobel, formerly of Cleveland, has been named superintendent of Robinwood Hospital, Toledo.

—Dr. W. G. Carlisle has been elected president of the staff of Bucyrus City Hospital. Dr. R. L. Solt was elected vice president and Dr. D. G. Arnold, secretary.

—The following appointments to the staff of Elyria Memorial Hospital have been announced: Active Surgical Staff—F. A. Lawrence, R. H. McClure, A. S. McKitrick, G. E. Moyer, J. P. Rankin, H. C. Stevens. Active Medical Staff—T. F. Cushing, G. E. French, R. W. Hancock, G. A. Hoke, H. M. Metcalf, George Mynchenberg, Jr., Z. Pitcher, O. E. Townsend. Active Obstetrical Staff—H. J. Austin, S. J. Birbeck, C. M. Herald, K. P. Scott. Active Eye, Ear, Nose and Throat Staff—J. T. Fawcett, C. O. Jaster, George Gill (Consultant), Orthopedic Staff—C. H. Heyman, chief, F. A. Lawrence, assistant. Pathologist—Maurice Rosenzweig. Roentgenologist — H. A. Mahrer. Associate Medical Staff—W. E. Hart. Associate Eye, Ear, Nose and Throat Staff—F. E. Glauner. Non-Resident Staff—D. C. Barber, Grafton; Phillip Katz, Valley City; James A. Schurgot, Grafton.

—The following officials and committees have been selected for 1934 by the staff of White Cross Hospital, Columbus: Chief of staff, Dr. W. P. Smith; vice chief, Dr. Frank Watson; secretary-treasurer, Dr. O. R. Rosenow; record committee, Drs. H. V. Weirack, Ruth Koontz and H. E. Boucher; program committee, Drs. Frank Watson, C. H. Solomonides and A. G. Helmick; intern committee, Drs. M. E. Milhon, Fred Fletcher and A. B. Landrum; out-patient-department committee, Drs. W. Silbernagel, J. E. Hoberg and E. H Baxter.

CA 3-8 GLD
AUG 1 1935

The OHIO STATE MEDICAL JOURNAL

OWNED AND PUBLISHED MONTHLY BY
THE OHIO STATE MEDICAL ASSOCIATION
AS A MEDIUM OF SERVICE TO ITS MEMBERS

MARCH 1, 1934 VOLUME XXX
Number 3

Resume of New and Important Workmen's Compensation Developments in This Issue, Pp. 171 to 173

This is the Last Issue of the Journal Sent to Delinquent Members Unless Dues are Paid Promptly. See Page 170.

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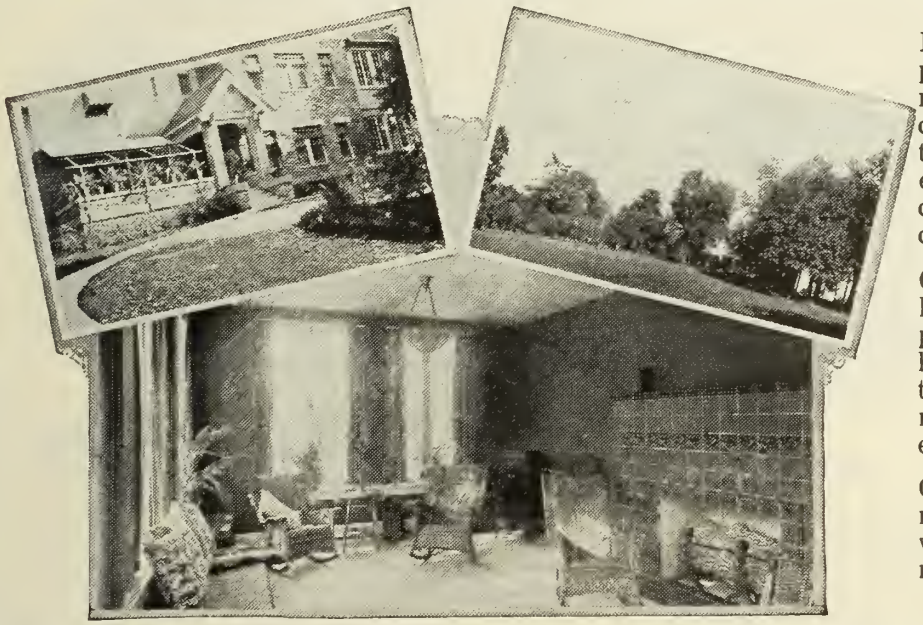


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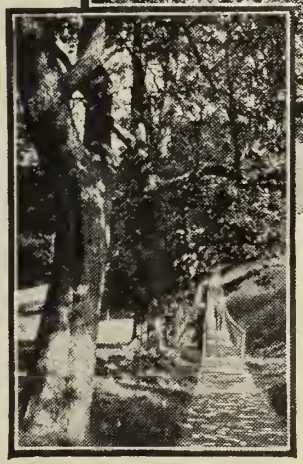
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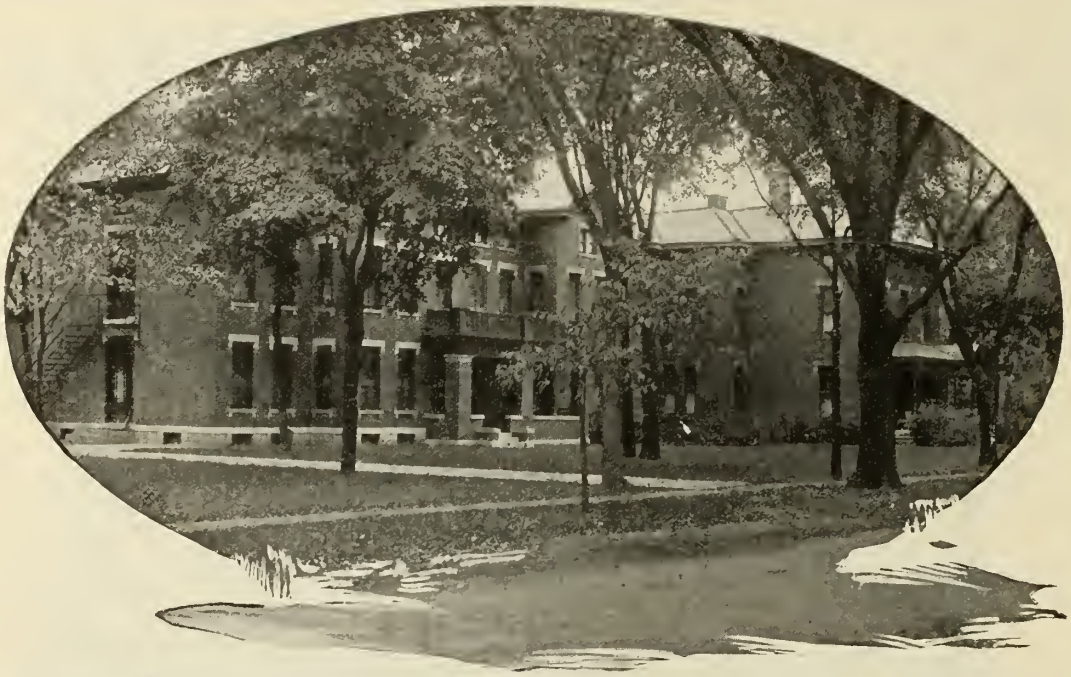




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TEMPERATURE (Mean monthly—40-year average)		49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8	
RAINFALL (In inches—40-year average)		.8	.96	.81	.32	.14	.23	.24	2.46	1.0	.6	.76	1.09	Total 11.57
HUMIDITY Monthly (40-year average)	A.M.	61.	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.1	46.8	57.1	74.2	Aver 49.5
	P.M.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1	48.1	29.9

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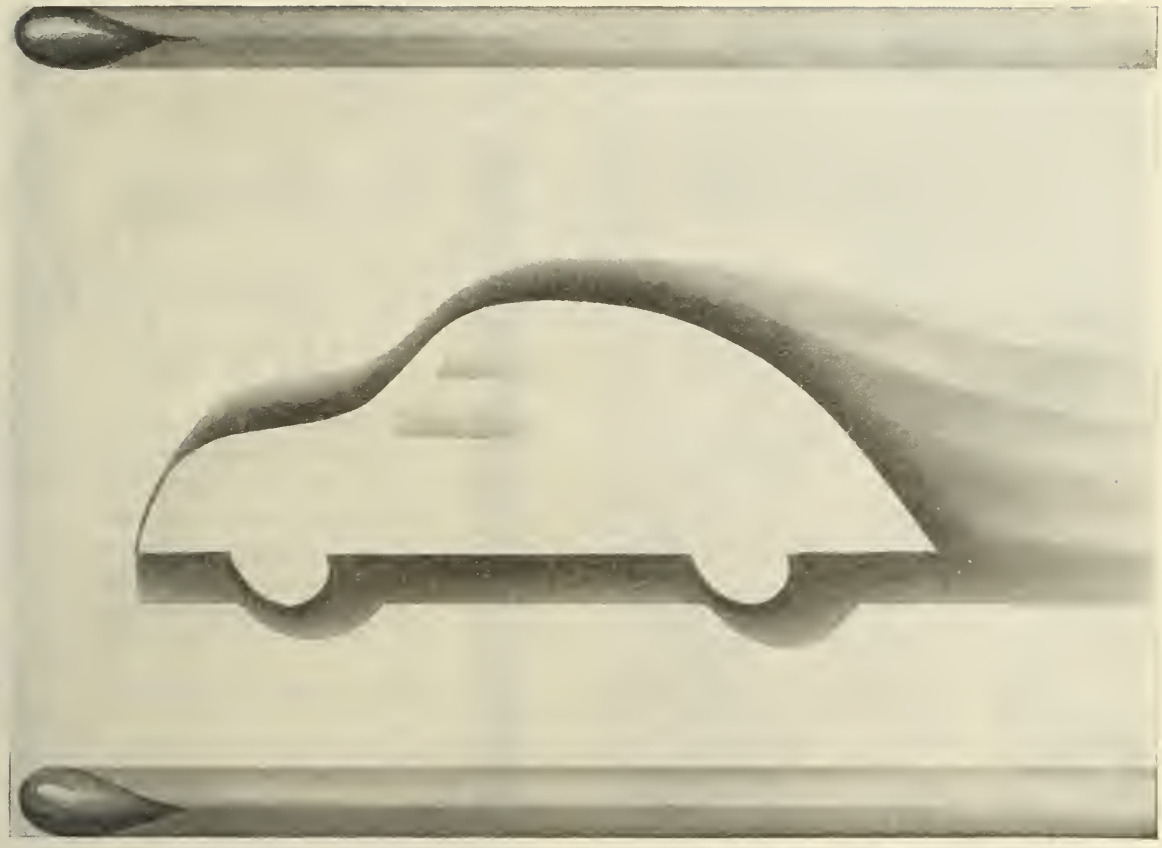
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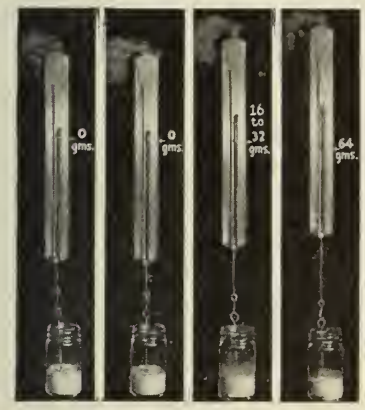
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[1] Morse and Talbot: Diseases of Nutrition and Infant Feeding, pg. 59.

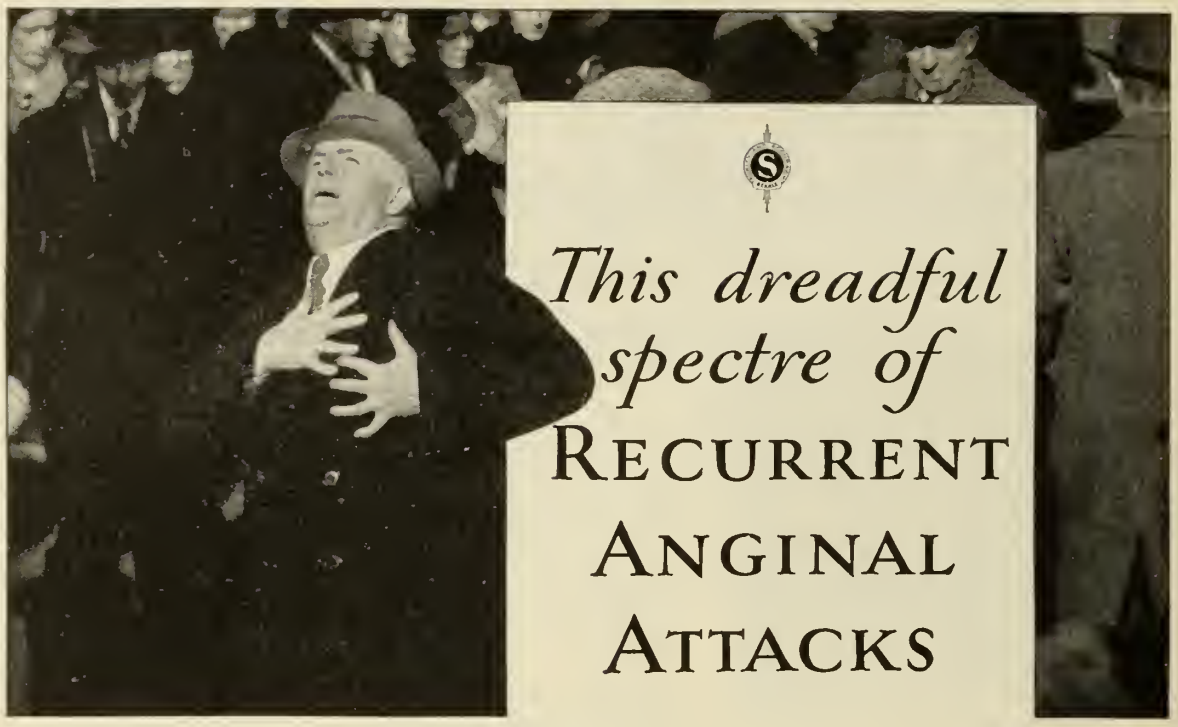
[2] Marriott: Infant Nutrition, pg. 43.

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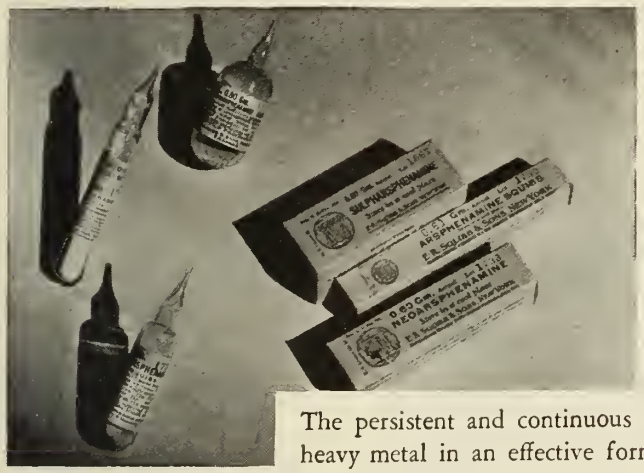
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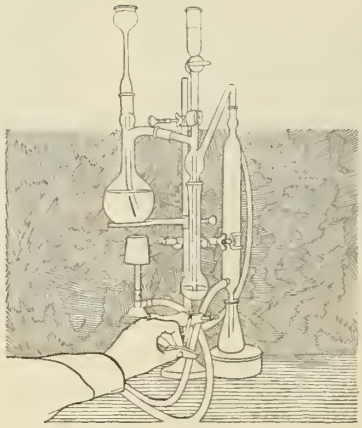
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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Stimulating Interest in Meetings

Judging from reports from many of the county medical societies and academies of the state, there never has been a time when the interest of physicians in the activities and functions of medical organization has been at a higher pitch and the attendance at meetings in general been as great.

Undoubtedly, this is because of the number and variety of the serious questions of vital concern to each and every physician which have arisen and demand concerted consideration by the profession as a whole.

All of which implies that sustained interest in organization functions and scientific activities can be created and maintained providing the membership is offered benefits comparable to the time and effort expended by the members in attending meetings and taking an active part in the affairs of the society.

In all probability interest in medical organization has been stimulated and the profession generally has benefited through the frank and serious discussions which have been held concerning the important problems confronting the profession today. Naturally, conflicting opinions have arisen, but for the most part they have been expressed openly and in a spirit of genuine effort to arrive at conclusions that will be of the greatest benefit to the majority of the profession.

Dr. Charles Fidler, president of the Milwaukee Medical Society, made a pertinent point recently when he declared:

"Divergent opinions are wholesome when openly discussed, but ruinous when clannishly fostered. Most of us, I believe, have similar ideas about the general principles of organized medicine; certainly all of us have the same idea regarding its destiny".

Naturally, to keep the membership actively interested in medical organization and its activities, each county medical society and academy must have an alert and active program committee, intent upon providing educational attractions for each meeting of the society so that interest and activity may be maintained or rejuvenated.

What constitutes a good medical meeting? Here, again opinions differ. However, there are certain general principles which may be followed as a fundamental basis upon which to proceed.

Writing in the *Iowa State Medical Journal*, Dr. D. J. Glomset makes some suggestions along this line which merit consideration. Quoting from his remarks:

"Man is so constituted that he can do better work and enjoy his labor more when he works in groups than as an individual. This is the reason for the existence the world over of a legion of human associatons. This is the reason for the existence of organized medicine. However, human groups, like human individuals, are prone to stray away from the straight and narrow path that leadeth to more abundant life. Therefore, it becomes necessary for each member of an association, and especially the officers, to have clearly in mind what the ideal goal for the society really is in order that they may steer the society persistently and consistently on the right course.

"Since our existence as a medical profession is justified only by our success in preventing and curing disease and in the alleviation of suffering from disease, it is obvious that the goal of any medical society is to make its members excellent physicians. This goal may be accomplished by:

"1. Keeping its members abreast of medical progress.

"2. Inspiring them to live up to the high ideals of medicine.

"3. Obtaining for its members the joy of living which comes from the friendships of their colleagues.

"The prime need of keeping its members well informed in medicine is recognized by every association of physicians the world over. Various types of programs are presented to fill this need. Some societies have their programs given by experts from afar. Others resort to what might be called the 'wheel-horse' method, whereby all programs are presented by the same few members. Still others obtain their scientific programs from as large a percentage of their own members as possible.

"It is generally conceded that the scientific standards of an individual society are highest where the last mentioned variety of program prevails. Real stimulation can after all come only from within the society. A medical society is active to the degree to which each individual member takes an active part in its functioning. Not all members can take an official part in the society's activities but each one can participate in the program. Medical meetings planned on this basis build for the society and for the individual doctor in the following ways:

"1. A discussion given by any member, whether it deals with his original observations or with his own views on a phase of medicine can never fail to interest and instruct the listeners provided that the individual has put his very best into his theme.

"2. Such a presentation never fails to produce in the minds of the rest of the members the desire to go forth and do likewise.

"3. Any doctor who has done his very best in presenting his subject is himself the greatest bene-

ficiary since such an effort never fails to make him a better physician.

"Religious leaders have always been cognizant of the fact that the zeal and good works of their flocks could be maintained only through constant inspiration of some kind. This applies equally well to medicine. A medical meeting that fails to leave in each member a desire to go forth and become a better doctor is not an ideal meeting.

"Medical meetings might be varied by occasionally inviting a guest speaker of outstanding ability in medicine. These men by their own achievement, by their personality and by their technic of presentation have a powerful revivifying influence on the society. The excessive use of such talent however leads to the stagnation and decay of the society.

"A good medical meeting is the most potent means for the promotion of good fellowship among the individual members of a society. In the stress of life in the professional competition of one's colleagues, irritating traits will occasionally crop out and cause resentment among his professional brethren. It seems to be the easiest thing in the world for the offending brother to make a mountain out of each molehill of this kind to the great detriment not alone of the offender and the offended but to the entire medical profession. Frequent medical meetings at which each doctor expresses his own medical views and hears and discusses the views of his colleagues, make it impossible for the injustices produced by petty jealousies, small indiscreet acts and other minor defects to distort the evaluation of a colleague in this way.

"Frequent medical meetings of the type outlined are doing wonders all over the state in uniting the medical profession into one solid body of intelligent, friendly physicians working together and enjoying working together for the benefit of the sick".

—O S M J—

Interesting "Welfare" Viewpoint

At a recent meeting in Columbus of social workers interested primarily in child welfare activities and in the administration of mothers' pensions, it was proposed that state and local relief officials be requested to seek from the Federal Government money to supplement local funds appropriated annually for such activities.

There was a distinct difference of opinion among those attending the conference relative to the wisdom and propriety of asking the Federal Government for funds with which to carry on welfare activities which heretofore have been supported by local funds and administered by local agencies.

The fear was expressed that should Federal funds be furnished, the Federal Government might take over the administration of these activities, or at least assume certain supervisory functions which would interfere seriously with present local administering agencies.

After prolonged discussion and despite the objections of a considerable number of those present, a resolution soliciting Federal aid for local child welfare activities and for mothers' pensions was adopted.

It is interesting to find a group of welfare workers trembling at the thought of Federal control, supervision, dictation and interference in local governmental activities or over the functions of agencies which have long been responsible solely to local sentiment and local policy.

For years, the medical profession has been dubious of encroachments and interference of state and Federal governments in the field of medical practice. In its opposition to excessive socialization of medical service, the medical profession has received no support from most of those individuals and groups engaged in social welfare activities. In fact, many enthusiasts among the welfare groups have given their active support to projects that smack of state medicine and have lent active encouragement to those promoting the complete socialization of medicine through governmental control or otherwise.

Now some of the ammunition that has been fired by some of the socially-minded groups who have been blind to practical social and economic problems and who have given their enthusiastic support to projects that have tended to disrupt medical practice and resulted in encroachments on the rights of the physician in private practice has proved a boomerang to plague them.

During the past few years, those engaged in welfare activities have witnessed the gradual trend toward the centralization of welfare work with a lessening of control and supervision by local agencies and individuals. Needless to say, they have not relished this development. Now that their toes and not someone else's are being trampled upon, they have raised a protest.

Even some of the most rabid enthusiasts in the field of social welfare are beginning to awaken to a realization that bureaucracy is undesirable and dangerous and that in the final analysis the people are better off if permitted greater freedom in running their own affairs through local individuals and agencies, responsible to their own local constituents and more familiar with local needs and conditions.

—O S M J—

Social Tendencies Affecting Medicine

What physician has not asked himself and others scores of times during recent months the same hypothetical question asked by the Hon. Joseph V. McKee, former mayor of New York City, in an address not long ago at the 87th anniversary celebration of the New York Academy of Medicine?

Discoursing on "Medicine and Modern Sociological Trends", Mr. McKee traced the constant and gradual extension of the activities of government in an effort to solve social and economic problems climaxed by the present period of ultra governmental control and supervision.

Then, as a preface to his remarks concerning the significance of the momentous events of the past few months from the standpoint of medical

practice and the medical profession, he asked:

"If this is the modern sociological trend—to look more and more to the government for the solution of our social, our economic and our business problems, what will be the effect upon medicine and medical practice that has shown a tendency to be most responsive to the great influences of every age whether it be Greek or Roman, English or American?"

All will agree with Mr. McKee that "this new collectivism means a portentious thing for medicine". None is able to predict the ultimate outcome. In this new but gradual collectivism, where will, or should, medicine take its stand? How should the profession proceed to meet some of the vital problems confronting it? What part does, or should the individual physician take in the present drama of economic, social and governmental changes?

A writer in a recent issue of the *New York State Medical Journal* commenting on the present situation made the following timely observation:

"With no desire to belittle the influences which have and are still bringing about changes in medical practice, nor to detract from the significance and merit of proper study of these by men qualified for this work and the benefits these may achieve for the individual physician or the entire profession, nevertheless individual success remains as before the result of individual effort. No amount of economic study and no extent avail the individual who expects his medical society or the government to improve his status. Personal incentive to find a proper place in the existing order of things and to rise according to merit, always was and still is the method of success. This is done by knowledge and work and not by demands on a committee of economics or the cry to them for relief from existing evils. The true family doctor has for all time been the servant, counsellor and friend of man. The social order may be upset and all men made equal thereby, but individual incentive will again lead to mastery in the final analysis of any scheme and the individual physician will again be servant, counsellor and friend".

Although the writer of the above may seem to some a bit optimistic, in the light of present developments, in his predictions, the logic of his conclusions concerning the relative value of personal incentive and initiative are sound and reasonable.

An excellent observation of similar vein which emphasizes not only the responsibility of the individual physician but also the necessity for and importance of strong and harmonious organized effort on the part of the entire profession is found in a communication from Dr. Oliver J. Fay, Des Moines, Iowa, to *The Journal of the American Medical Association*, and published on page 476 of the February 10, 1934, issue of that publication.

After commenting favorably on the attitude of federal officials in general toward the medical profession and on the fact that "the medical profession has thus far not only escaped hampering federal restrictions but has in a sense received federal endorsement, a vote of confidence from the government, as it were", Dr. Fay appended the following warning and word of advice:

"There is, however, nothing permanent, nothing unchangeable, about the present regulations. The profession still faces a very real danger. If tomorrow the government should find that certain physicians are failing to abide by this code, it can provide new regulations; it can take over the entire medical work of the C.W.A., arrange to have it done by salaried government employes, so take the first steps toward state medicine.

"In other words, you and I, the members of the medical profession as a whole, are at the mercy of the individual physician; our fate, whether or not we are to continue as individual members of a great profession, or are to become mere cogs in the machine called state medicine, depends on whether each and every one of us plays the game. Unless we are mere dreamers, we must admit that no large group of humans is 100 per cent perfect, and we must face the fact that there are sure to be those who will seek personal profit at the cost of the group welfare—unless we as an organization control them.

"Group control through organized medicine is the answer to our problem. If it is to be every man for himself there can be no question but that we will soon find state medicine a reality. Because I believe that state medicine would be a mistake, a tragedy, not only from the standpoint of the individual physician but from the standpoint of the welfare of the nation and the continued advancement of medical science, I want to stress once more *the vital need for organization, for strong organization, in medicine. Such organization, and only such organization can insure freedom to the idividual and to the profession in medicine.* Individualism and freedom in scientific pursuits have meant advancement in the past and we must look to them for advancement in the future. *Organized medicine must have the support of every thinking physician if we are to continue to advance.* Working as individuals, we can do nothing to stem the tide if it turns toward state medicine.

"As members of a great national organization, the American Medical Association, we can do much. But we must remember that this national organization is strong only as it has the support of its component state medical societies, and that these societies are strong or weak as the county medical societies that compose them are strong or weak, loyal or indifferent. Now is the time for each component county society to show its strength and its loyalty, to hold its membership to the spirit of the hippocratic code that we may escape membership in a mere trade union and the code of control of the federal government".

In this present period of uncertainty and hardship for members of the medical profession, it is difficult for many physicians to see how there can ever be a complete return to the golden days which permitted the unrestricted freedom of personal initative and enterprise. The present outlook is that that time may never repeat itself in history. However, as both commentators quoted have intimated, individual effort always will continue to play a major role in all our social endeavors; in medicine especially. For that reason, the future of medicine will depend to a large extent on the character, ambitions, education and enterprise of the individual physician as in the past, augmented, supported and protected by strong and effective organized activity.

The President's Page

A Personal Communication to the Membership from

C. L. CUMMER, M.D., *President*, Cleveland, Ohio

IT IS becoming increasingly evident that every member of medical organization has an important role to play in our ever-continuing campaign for the protection of public health and the ideals of scientific medicine.

At each session of the State Legislature there are introduced many bills of potentially great importance to us as a profession. The gradual extension of government into all fields of activity has multiplied our problems in carrying out one of the important functions of our State Association, namely: To encourage the enactment and enforcement of just medical and public health laws and to arouse public sentiment against those things detrimental to public health and scientific medicine.

In an abstract way, some members of our Association expect it to present to the members of the Legislature and other public officials by some method—perhaps not clearly visualized—the cause of medicine, interpreting to them the modern and scientific viewpoint about measures of vital concern to our profession and requesting that the interests of the public, as well as the profession, be protected. Apparently, it has never occurred to some of our members that success in such matters cannot be attained by waving a magic wand or through the activities of a comparatively few willing and alert colleagues.

Close observation of public action, impending legislation and the activities of state bureaus and commissions, is truly an urgent duty of our Association and one which must be discharged faithfully in the public interest. The leadership in this important function has been delegated to our Committee on Public Policy and the staff of our state headquarters office. Many of us might be inadequately and inaccurately informed about public activities affecting public health, scientific medicine and medical practice were they not followed from their incipiency by them. Our central organization can and does follow developments effectively, studying especially the implications and possible effects of social and medical measures and regulations. It frequently presents the ideas of organized medicine to legislators and legislative committees, state officials, and state commissions and bureaus.

However, we should remember that after all, our group is only one of many which has definite ideas about debatable questions and our ideas often are in conflict with those of other groups. Moreover, we have no legislative power or executive authority, a fact which some of our members do not seem to realize. In the last analysis, this authority rests with the people whose representatives sit in the State House. The voices to which legislators and other public officials listen are the voices of their contituents.

It is obvious, therefore, that the efforts of our headquarters office and our Committee on Public Policy, which are the central nervous system of our organization, must be translated into action by each and every component society in the state.

Physicians must exercise their rights of citizenship not only for the public good but in the interest of themselves and their profession: First, by ascertaining the views of candidates for public office before nomination and election; secondly, by quietly and unobtrusively aiding in the nomination and election of those who are well qualified and at least open-minded about medical questions; and, finally, by seeing that their representatives are kept constantly informed of the correct attitude toward medical and health problems.

This means vigorous and unflagging effort, based on accurate knowledge and guided by diplomacy. The direction of such local effort should be entrusted to the legislative committeeman (or committee) in each county society. The committeeman is the liaison officer between the headquarters and the front. To him and to the county society officers is sent information from our headquarters office, often confidential in nature. The significant points in bulletins from the state headquarters office should be communicated to the membership either at regular meetings or by some other effective method. This demands prompt and effective action. Delay on the part of local legislative committeemen until an important medical measure is ready for final vote in the legislative chambers before presenting the views of scientific medicine to their local legislators is the height of futility.

Our Committee on Public Policy and our headquarters staff are given the responsibility of planning the strategy in our efforts and activities in legislative and governmental affairs. While they may call the plays, they cannot carry the ball all the time. Consistent teamwork on the part of the component societies and individual members is absolutely essential for success. Only by corodinated and concerted action can the interests of public health, scientific medicine and of the profession be protected.

It is my sincere hope that while the component societies which have cooperated in the past in this vital part of our program redouble their efforts, that those which have been negligent or half-hearted, reorganize this phase of their activities under an alert and diplomatic committeeman or committees, and that after this is done, every local member support his committeeman, or committeemen, by personal and individual effort. Our legislative and governmental contacts and activities can be made even more effective than they are at the present time if greater initiative and energy is expended by every local unit of our State Association.

NEWER ASPECTS OF THE MANAGEMENT OF HYPERTHYROIDISM*

By GEORGE M. CURTIS, M.D., F.A.C.S., AND FRANCIS J. PHILLIPS, A.B.,

COLUMBUS, OHIO

DURING the past seven years a considerable amount of new information has become available concerning the relationship between iodine metabolism and the activity of the thyroid gland.[1] A part of this concerns the problem of hyperthyroidism. The newer aspects of the management of hyperthyroidism which we wish to present at this time are those which result from the extension of our understanding of this morbid process by the application of these newer facts. We would, therefore, consider three phases of iodine metabolism in their significance to hyperthyroidism:—the blood iodine; the iodine of the thyroid gland; and the urinary excretion of iodine.

It would seem that the next step in determining more clearly the significance of iodine in hyperthyroidism should be a more thorough study of the iodine metabolism. Methods are now available by which this study may be made[2,3,4]. During the past four years a group of us—Davis, Cole, Phillips, and I—have investigated extensively certain features of iodine metabolism in normal individuals and in over 150 patients with various diseases of the thyroid gland. For the determination of the iodine in the blood, urine and tissues, we used first a method devised by Davis,[2] and later, one amplified by Phillips,[3] which are, essentially, developments of von Fellenberg's original procedure.[4] In these studies we have found a definite and significant relationship between the iodine content of the blood and the activity of the thyroid gland.[5]

The constant occurrence of iodine in normal human blood is now firmly established. The convincing demonstration of this fact has followed the development of modern micromethods,[4] designed particularly to detect the minute amounts consistently present in clinically obtainable quantities of blood. The normal iodine content of human blood is about 12 gamma per cent. A *gamma* is one one-thousandth of a milligramme, 0.001 mg. There is, consequently, normally twelve one-thousandths of a milligram of iodine in 100 cc. of whole blood. This level is greatly elevated in patients presenting diffuse hyperplastic goiter with hyperthyroidism. (Figures 1, 2, 4.) We have found it to be as high as 40 gamma per cent. It averaged 27 gamma per cent in a series of eleven patients whose basal metabolic rate averaged plus 50.[5] This fact was originally discovered by Veil and Sturm.[7] After an adequate thyroidectomy, with the subsequent relief from the symptoms of the hyperthyroidism, the blood iodine falls to a low normal level. (Figures 1, 2.) This ensues after the cessation of postoperative iodine administration. If the thyroidectomy is inadequate, or if one lobe alone is removed, associated with the persistence of the symptoms, there is a maintained elevation of the blood iodine. (Figure 2.)

In toxic nodular goiter, the blood iodine is also elevated; however, not so high as in genuine Grave's disease. (Figure 3.) This is correlated with the lesser severity, more chronic course and the lesser elevation of the basal metabolism in toxic nodular goiter. After an adequate thyroidectomy, the blood iodine falls to a low normal level[1, 5].

In non-toxic nodular goiter, the blood iodine is within the normal range. We have found it at a low normal level[5]. It is but little changed following a thyroidectomy. However, in these patients, less of the entire gland is removed and considerably more is left behind. In patients with hypothyroidism, either congenital, acquired, or operatively induced, the blood iodine is low[5]. It rises sharply following medication with desiccated thyroid, and, after continued medication, maintains a high normal level. The blood iodine is elevated in certain other diseases, notably in lymphatic leukemia[5].

These studies, indicating a definite relationship between thyroid function and the blood iodine level, finally resulted in our making similar investigations of the urine[12]. A small amount of iodine is constantly present in the daily twenty-four-hour excretion of urine. The nature of the chemical combination of this iodine we have not determined. However, a part of it is alcohol insoluble, and a part is alcohol soluble. In University Hospital patients on the usual hospital diet, which contains no iodized salt, the daily excretion of iodine varies between 25 and 75 gamma per day, or between 25 and 75 one-thousandths of a milligramme, (.025 — .075 mg. daily). In patients with genuine Grave's disease, presenting diffuse hyperplastic goiter accompanied by exophthalmos and the characteristic symptoms of hyperthyroidism, the urinary excretion of iodine is elevated[12]. We have found this particularly in the early stages of the untreated exacerbation. In the later stages of the disease this increased excretion of iodine in the urine is not so evident. This finding is to be particularly correlated with loss of iodine by the diffuse hyperplastic gland. It is correlated with the fact that the diffuse hyperplastic goiter of Grave's disease is low in its iodine content; also that the blood iodine is elevated.

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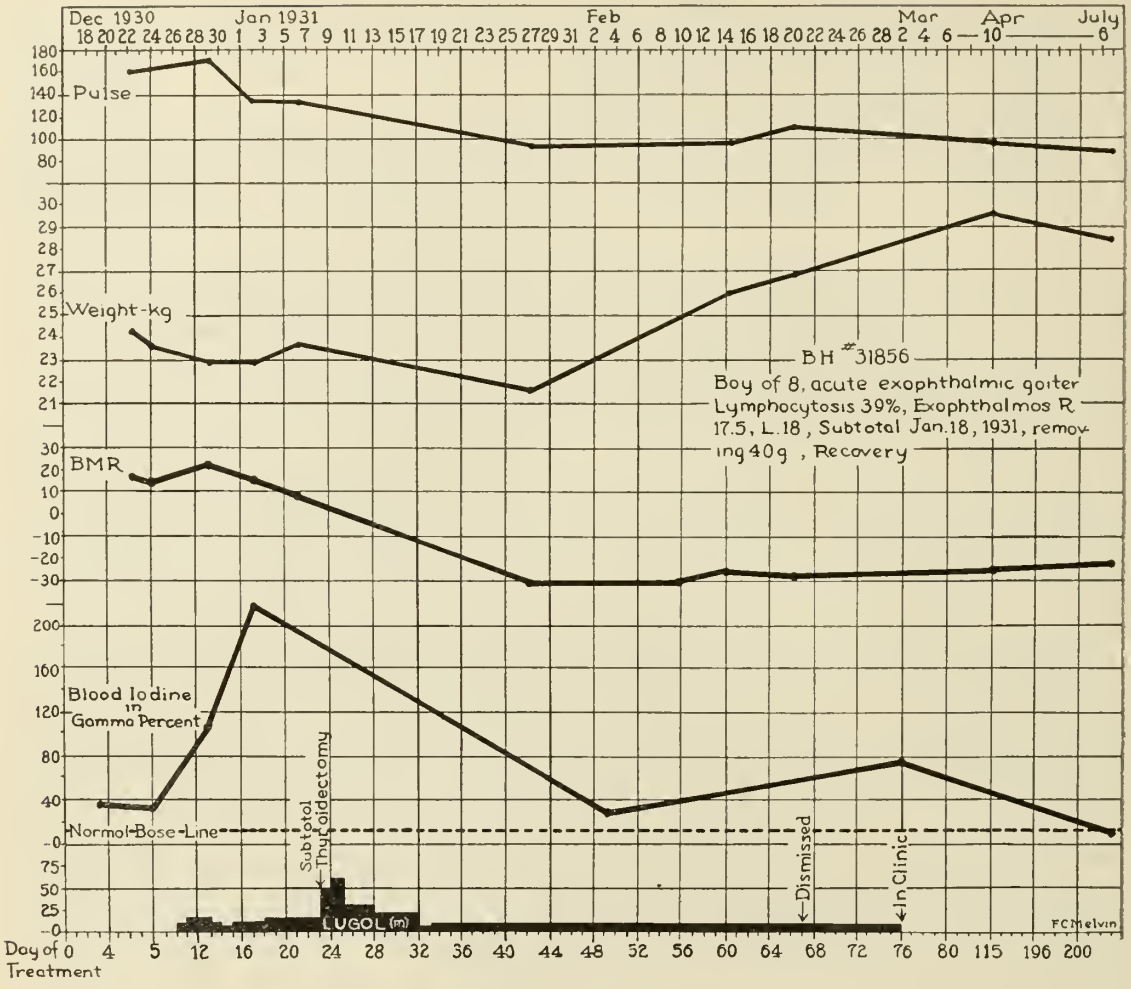


FIGURE 1

The blood iodine in juvenile thyrotoxicosis (11). Note the high initial level and the fall to a low normal level after adequate thyroidectomy.

Following Baumann's discovery[8] of considerable quantities of iodine within the thyroid gland, there ensued a renewal of interest in iodine metabolism in its relation to goiter. Baumann found, and this has since been frequently confirmed[9], that the diffuse hyperplastic gland of true Grave's disease was low in iodine[8]. This fact is of significance in the development of our modern theory regarding the nature of exophthalmic goiter. The normal thyroid gland contains about 10 mg. of iodine[9]. In glands showing the characteristic diffuse hyperplasia of exophthalmic goiter, the contained iodine may be reduced to as low as 3 mg[9]. This is due to the fact that these glands contain practically no colloid. Upon iodine administration the alveoli fill with colloid and the iodine content of the gland increases[9]. This increase may be up to ten times the original amount contained. Since the normal gland contains about 10 mg. of iodine, and since the diffuse hyperplastic glands contain less, it would seem only empirical to administer such large quantities of Lugol's solution as 30 minims a day, since this contains 226 mg. of iodine. Our studies have shown that this extra iodine is rapidly excreted in the urine[3].

Subsequent to the usual preoperative lugolization, 30 minims daily, in the management of hyperthyroidism, the blood iodine is greatly elevated. (Figures 1 and 2.) This elevation is irregularly maintained so long as lugolization is continued. Immediately following the subtotal thyroidectomy there ensues a fall in the blood iodine[13]. The irregular postoperative elevation during lugolization is usually maintained at a lower level.

An explanation of this iodine paradox, a rise in the blood iodine accompanied by definite amelioration of the clinical picture, is afforded by the studies of Lunde and his associates[10].

It is not necessary to employ Lugol's solution in preparing patients with hyperthyroidism for thyroidectomy. Iodine is necessary. It makes little difference in what form it is administered[14]. We have used smaller doses, 10 mg. daily, with as consistent success as in those instances in which we have administered 226 mg. daily as 30 minims of Lugol's solution. Furthermore, we have given

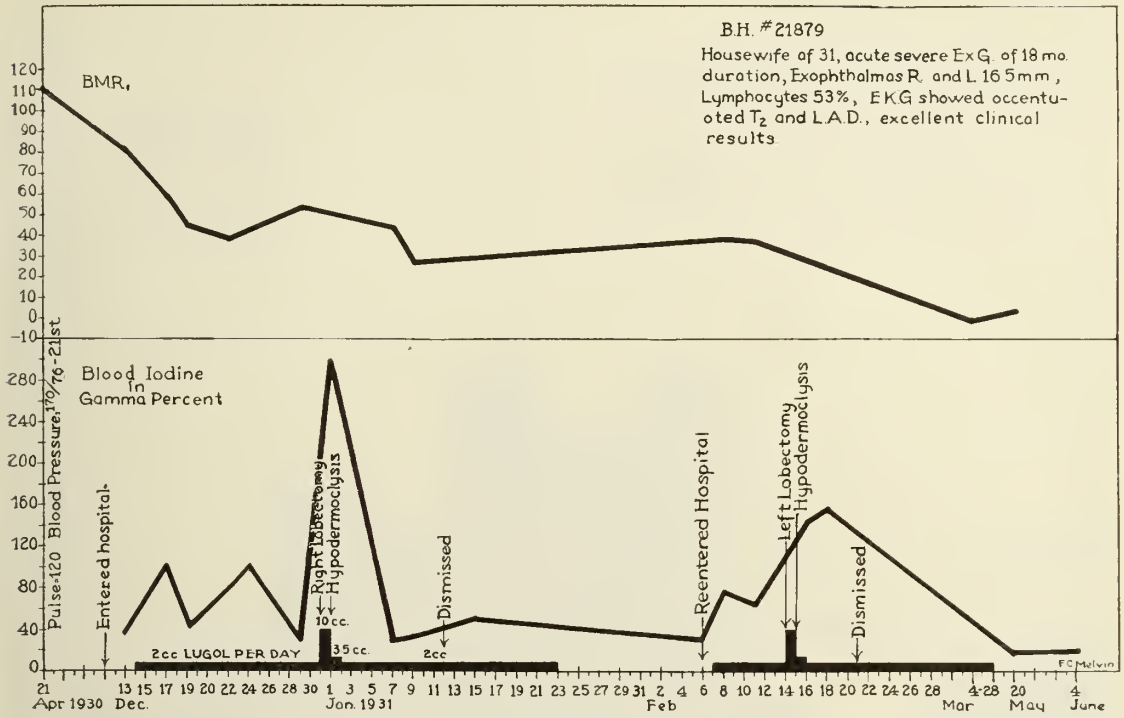


FIGURE 2

The blood iodine in severe exophthalmic goitre. Note the high initial level, the continued elevation during the unmedicated interval and the fall to a low normal level after adequate thyroidectomy.

the iodine in lipin combination. (Figure 3 and Case 3.)

These newer aspects concerning the behavior of the blood and urine iodine in the management of hyperthyroidism are best presented in a series of case reports which follow. The data are graphically shown in the corresponding charts:

IODINE METABOLISM STUDIES

Case Reports

Case 1. (See Figure 1.) (11).

Acute severe exophthalmic goiter in a boy of eight; blood iodine elevated; usual lugolization with usual rise in the blood iodine; subtotal thyroidectomy followed by severe acidosis and acute dilatation of the stomach; continued lugolization with usual continuance of the elevated blood iodine; subsequent fall in the pulse rate and B.M.R. with weight increase; the blood iodine fell to a low normal level after the cessation of lugolization.

This little patient entered the University Clinics December 13, 1930, presenting an evident goiter, exophthalmos and a tachycardia ranging around 140. A striking restlessness and an obvious tremor were noted. There was no familial goiter. No specific cause for the onset of the thyrotoxicosis was elicited. There had been an increased food intake but a continued weight loss. His condition had been first recognized by his school nurse.

Examination revealed an unusually warm, moist skin, as well as other more unmistakable signs of exophthalmic goiter. The thyroid was diffusely enlarged. No bruit was audible. Exophthalmos, accurately measured by the Hertel exophthalmometer, was R. 17.5 mm. and L. 18 mm. Convergence was decreased, the palpebral fissures were widened, and there was positive bilateral lid lag. The pupils and fundi were normal. Muscular weakness was evident upon unusual exertion. The spleen was not palpable nor were the lymph glands enlarged.

Owing to the obvious diagnosis the boy was hospitalized for study. The pulse, B.M.R., and blood iodine were all elevated. (Figure 1.) The blood iodine was three times its normal level, averaging 36 gamma per cent. Fluoroscopy revealed tracheal deviation to the left, but no evidence of an enlarged thymus. There was no anemia; R.B.C. 4,900,000, hemoglobin 105. There was a lymphocytosis; W.B.C. 6,700, lymphocytes 39 per cent. The urine revealed an occasional trace of albumen. Roentgenologically the heart was normal in size. An E.K.G. on December 20th revealed a sinus tachycardia (157). T_2 was accentuated and the P-R interval increased. There was no left axis deviation.

Previous to lugolization no clinical improvement was evident. During ten days of observation the weight fell from 26.2 to 23.3 kg. This was apparently due to the patient's being unaccustomed to the excitement of ward life, as well as to the severity of the hyperthyroidism. Lugolization was commenced on December 26th. (Figure 1.) For five days little amelioration could be noted. The blood iodine rose to 113 gamma per cent. This is the usual finding in patients being lugolized. There was even a slight subsequent rise in the B.M.R. On January 2nd, obvious improvement was evident. The blood iodine was 218 gamma per cent. The weight curve continued to fall. (Figure 1.) The blood pressure was 130/90. Owing to the continued severity of the disease, even upon rest and lugolization, surgery was decided upon. Preliminary polar ligation was not seriously considered, and a one stage partial thy-

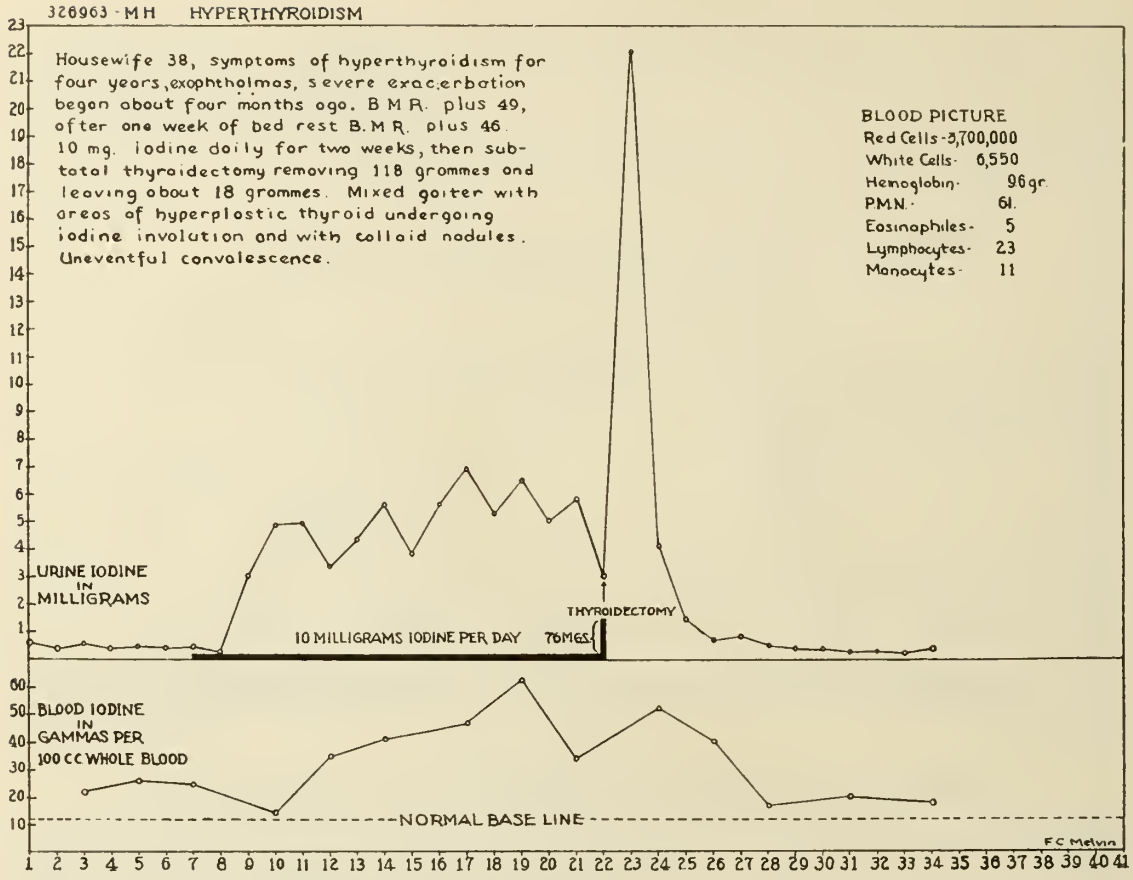


FIGURE 3

Iodine metabolism in hyperthroidism. Note the elevated initial level of the blood iodine, the increasd urinary excretion, and the rising curve of excretion subsequent to daily administration of 10 mg. of iodine.

roidectomy, leaving more of the gland than usual, was planned.

Nembutal, 1.5 grains, was administered by mouth the evening before operation. It was repeated early in the morning of operation. No morphine was administered. The boy was quiet when he came to the operating room. Ethylene-oxygen anesthesia was used, and between 30 and 35 per cent oxygen was administered throughout. The thyroid was diffusely enlarged and surprisingly avascular. The strap muscles were not transected, and a rapid operation with a minimum blood loss was possible. The respirations, around 25, fluctuated but little during operation. The blood pressure 156/92 during the incision, fell to 124/60 during the closure of the wound. Forty grammes of goiter were resected, leaving a piece 3 x 2 x 2 cm. on the right side, and 3 x 2 x 1 cm. on the left. More than usual was left owing to a consideration of the needs of future growth and adolescence.

Convalescence was complicated by the development of an acute and persistent acidosis. Postoperative restlessness was marked. Nembutal was ineffective and restraint was necessary. It was eventually controlled by morphine. Ringer's solution, containing iodine as Lugol's solution, was freely administered. Seven hours after thyroidectomy there was a marked acetonuria but no glycosuria. On the second day vomiting became frequent. Glucose was given freely. The pulse ranged around 160, the temperature rose to 103.6 F., and the respirations varied between 24 and 32. Later, abdominal distention was noted. Percussion revealed acute dilatation of the stomach. After lavage the vomiting ceased.

Improvement was evident upon the third day. From then on, convalescence was slow but progressive, and marked by a persistent acetonuria and occasional vomiting. The boy was discharged February 21.

The resected goiter weighed 40 grammes. The cut surface revealed moist colloid. No nodules were found. The alveoli were principally colloid filled, and lined by low epithelium. Areas of hyperplasia were evident, with columnar epithelium and papillary infoldings. The gland was, thus, the characteristic diffuse hyperplastic gland undergoing an iodine induced colloid involution.

The blood iodine remained elevated so long as lugolization was continued postoperatively. It subsequently fell to a low normal level, 10.3 gamma per cent. (Figure 1.) Six weeks' postoperatively exophthalmos was still present, although less evident, owing to the narrowing of the palpebral fissures. The B.M.R. finally stabilized around minus 22. This was doubtless the normal level since there was no evidence of hypothyroidism. We have discussed this point elsewhere in originally reporting this unusual case[11]. The Chvostek and Trousseau signs were negative throughout.

This study illustrates particularly that the blood iodine in juvenile thyrotoxicosis is also elevated, and that it behaves under management as does that of adults with the disease.

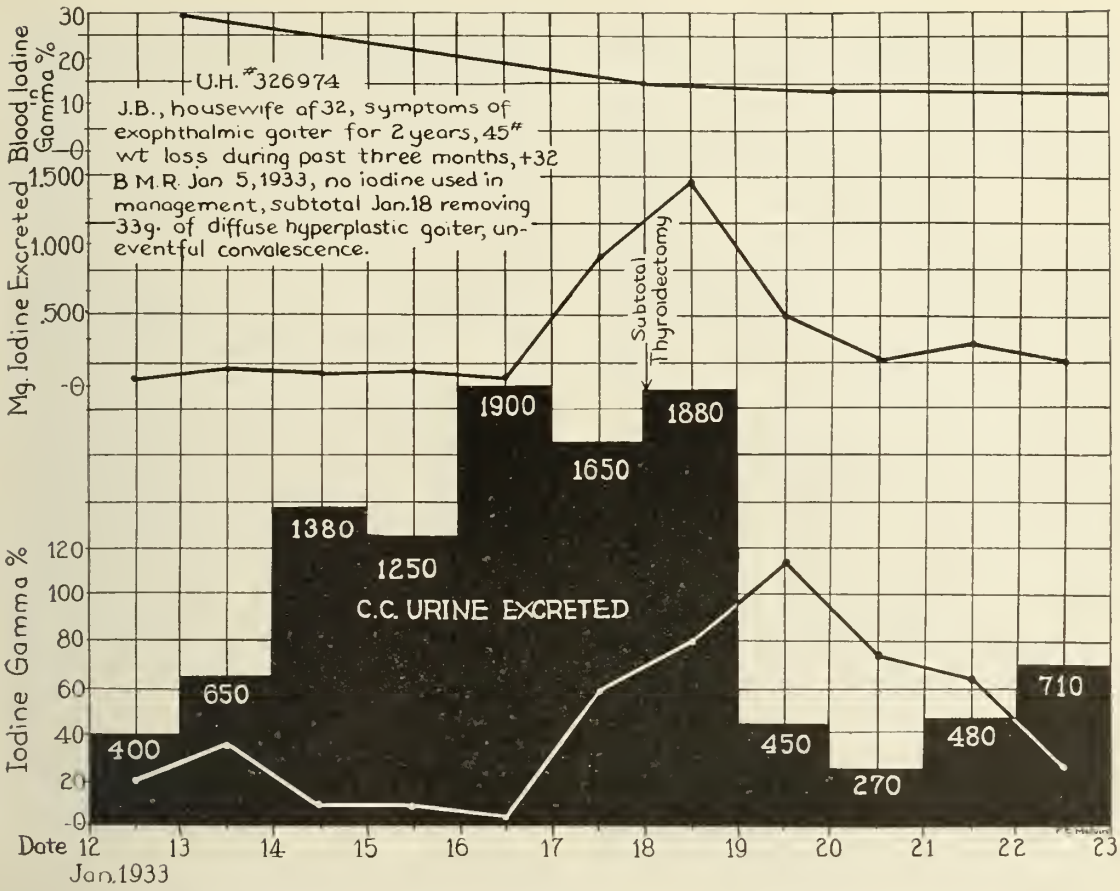


FIGURE 4

The urinary excretion of iodine in moderate exophthalmic goiter. The daily excretion is increased. Note the increase prior to thyroidectomy.

Case 2. (See Figure 2.)

Acute severe exophthalmic goiter in a housewife of 31; B.M.R. and blood iodine elevated; usual preoperative lugolizaton with usual rise in the blood iodine; two stage subtotal thyroidectomy with an interval "iodine vacation"; the blood iodine, also the B.M.R., remained high during the unmedicated interval; relugolization for stage two; blood iodine, and also the B.M.R. fell to a low normal level subsequent to the cessation of postoperative lugolization.

This patient entered the University Clinics in April, 1930, presenting a striking picture of severe exophthalmic goiter. She had noted symptoms for at least eighteen months. On April 21 her B.M.R. was plus 111, with the pulse at 120 and the blood pressure 170/76. There was no evident cardiac damage. Immediate hospitalization, with iodinization and eventual thyroidectomy was advised. It was completely refused. The patient rejected any management, and we lost track of her until December 1930. At that time the continued severity of the disease forced her to accept hospitalization and management.

After two days' hospital rest her B.M.R. was plus 81. The blood iodine was 36 gamma per cent, or three times the normal level. The usual lugolization was instituted, subsequent to which the B.M.R. fell. (Figure 2.) The blood iodine was irregularly elevated.

Owing to the severity of the nervous manifestations, a two stage lobectomy was planned. On December 31, a right subtotal lobectomy was made under ethylene anesthesia. There was a moderate reaction and an otherwise uneventful recovery. Immediately postoperatively 2 cc. of Lugol's solution was administered in a hypodermoclysis of 1500 cc. of Ringer's solution. During this administration the blood iodine was high. (Figure 2.)

Subsequent to the right subtotal lobectomy the blood iodine remained irregularly elevated during the period of postoperative lugolization. (Figure 2.) At the end of an "iodine vacation", two weeks after the last iodine was given, it was still elevated, 32 gamma per cent. It again rose and maintained an irregularly high level during the lugolization preparatory to the left subtotal lobectomy. (Figure 2.)

On February 14, the left subtotal lobectomy was made without incident. There was a mild reaction and an uneventful convalescence. Subsequent to the postoperative cessation of lugolization the blood iodine fell to a low normal level. (Figure 2.) The B.M.R. at this time was plus 4.

This study illustrates particularly that the blood iodine remains elevated between the two stages of a two stage subtotal thyroidectomy.

Case 3. (See Figure 3.)

Hyperthyroidism in a housewife of 38; "mixed goiter" (struma diffusa parenchymatosa et struma nodosa colloides) with exophthalmos; B.M.R. elevated to plus 48; blood iodine elevated to 25 gamma per cent; increased urinary excretion of

iodine; iodine preparation; subtotal thyroidectomy; subsequent fall in the B.M.R., blood iodine, and urinary excretion of iodine.

This housewife of 38 had noticed the presence of goiter for four years. There had been some evidence of toxicity. The present acute exacerbation began four months ago. It was accompanied by tremor, persistent tachycardia, obvious enlargement of the thyroid, and exophthalmos. Menstruation was decreased. The larynx and trachea were negative; heart negative, save for the tachycardia; bruit audible over the goiter; secondary anemia; no lymphocytosis, although the excised gland later revealed a heavy lymphocytic invasion; blood pressure 100/32; icterus index normal; cell volume normal; fragility normal; urine negative; Wassermann negative.

She was hospitalized for study January 5th. The *B.M.R. was elevated,* averaging plus 48. The *blood iodine was high,* averaging 25 gamma per cent. The *urinary excretion of iodine was greatly increased,* averaging 0.483 mg. daily. During the first week of study no iodine was used or administered. The results of this study are graphically presented in Figure 3.

Ten mg. of iodine daily was begun at noon on January 13. This was given in organic combination, as a lipiodine, "oridine". It was continued for two weeks. (Figure 3.) During the ensuing first day there was a low urinary excretion of iodine. It is difficult to account for this unless iodine impoverishment of the thyroid gland and tissues is postulated, in which condition they would, presumably, more readily take up the administered iodine. The blood iodine of January 15, 15 gamma per cent, is unusually low for a determination made during iodine administration. The remaining blood iodine values are elevated, as we have found to be the rule during iodine administration.

The urinary excretion of iodine, subsequent to the daily administration of 10 mg., is graphically presented in Figure 3. The concentration is greatly increased. There is a progressively increasing excretion of iodine, presumably as the impoverished thyroid gland and tissues become saturated. During the first eight days the daily excretion averages 3.8 mg. During the last seven days it averages 5.5 mg.

After this adequate preparation subtotal thyroidectomy was made January 28th without incident. 118 gm. of goiter was removed, leaving about 18 grammes. There was a moderate postoperative reaction, followed by an uneventful convalescence. The goiter removed was composed of diffuse hyperplastic tissue containing many small colloid nodules. There was a heavy lymphocytic invasion. The hyperplastic portion of the goiter contained 68 mg. per cent of iodine. The colloid nodules contained only 23 mg. per cent.

The effects of the thyroidectomy are graphically presented in Figure 3. Immediately following operation 76 mg. of iodine, as Lugol's solution, was administered in a hypodermoclysis of 1500 cc. of Ringer's solution. About a third of this was recovered in the urine. No more iodine was subsequently used or administered.

The blood iodine gradually fell to a low normal level. It was still elevated, 18 gamma per cent, on February 9. The B.M.R. was plus 20, on February 9, with P. 92—T. 98.6—R. 16 in the basal state. The urinary excretion of iodine was also decreased. During the last week it averaged 0.330 mg. daily, in contrast to the 0.483 mg. daily of the first week.

The stool iodine was 2.9 gamma per cent after 11 days during which no iodine was administered. The daily stool excretion of iodine averaged, during this period, about 0.005 mg. (5 gamma) daily. After 11 days of 10 mg. of iodine daily, the daily stool excretion was about 0.559 mg. (559 gamma). Calculation revealed that only about 60 per cent of the entire 226 mg. of iodine administered could be accounted for. A part of this discrepancy is presumably due to the taking up of iodine by the body tissues as well as by the thyroid. Another part of the unrecovered iodine is lost in the perspiration.

This study raises a number of significant questions regarding the iodine metabolism in toxic goiter. The characteristic picture of exophthalmic goiter was observed, although colloid nodules were found in the diffusely enlarged thyroid. The B.M.R. was elevated, the blood iodine was elevated, and there was an increased urinary excretion of iodine. The stool iodine was low. A rising curve of iodine excretion followed the administraton of iodine. The stool iodine was then elevated. Subtotal thyroidectomy was uneventful. More iodine was found in the diffuse hyperplastic portions of the goiter than in the small colloid nodules. Subsequent to the thyroidectomy there was a fall in the B.M.R., the blood iodine, and the urinary excretion of iodine. Only about a third of the postoperative 76 mg. was recovered in the urine. In all, about 60 per cent of the iodine adminstered was recovered in the urine, excised gland, and in the stool. There is doubtless considerable iodine loss in the sweat.

This study presents the characteristic triad of hyperthyroidism; elevation of the B.M.R., elevation of the blood iodine, and, in the early stages, an increase in the urinary excretion of iodine.

Case 4. (See Figure 4.)

Moderate exophthalmic goiter in a housewife of 32; blood iodine elevated to 29 gamma per cent; increased urinary excretion of iodine averaging 106 gamma daily; elevated B.M.R. to plus 32; no iodine administered; blood iodine and B.M.R. fell upon bed rest; subtotal thyroidectomy followed by definite transient increase in urinary excretion of iodine; B.M.R. and blood iodine subsequently fell to low normal levels.

This housewife of 32 was first seen in the Dispensary in January, 1933, presenting the symptoms of moderate exophthalmic goiter. The B.M.R. was plus 32. She had noted the presence of goiter for years. There was some evidence of previous toxicity. She had a panhysterectomy and a partial oöphorectomy in April, 1931. Part of one ovary was left. The present exacerbation of hyperthyroidism began about three months previously, with characteristic symptoms and an unusual weight loss. The thyroid was diffusely and symmetrically enlarged. No nodules were palpable. The heart was negative save for a tachycardia. The blood was normal save for 30 per cent lymphocytes; blood pressure 135/85; urine negative, Wassermann negative. She entered the hospital 1/4, and eight days of bed rest preceded this study. No iodine whatever was used or administered. On 1/17 the B.M.R. had fallen to plus 6.

The blood iodine was at first elevated, but fell to 16 gamma per cent, together with the B.M.R., upon the institution of adequate bed rest. There was an increased urinary excretion of iodine. These findings are presented in Figure 4. Following the thyroidectomy, the urinary excretion of iodine rose to 1497 gamma per day. This increase gradually subsided. (Figure 4.) Just previous to the thyroidectomy there also occurred a definite

increase in iodine excretion. This may have been due to the excitement of the impending operation.

This study shows that immediately following thyroidectomy there is an increased urinary excretion of iodine. Presumably this is due to absorption of iodine from the raw surfaces of the injured gland. It may be due to losses from the other tissues.

SUMMARY

The newer aspects of the management of hyperthyroidism which we have presented concern particularly the relationship of iodine metabolism to the usual clinical management of this disease. They may be summarized as follows:

The blood iodine is elevated in hyperthyroidism. This elevation is greater in exophthalmic goiter than in toxic nodular goiter. It falls to a limited extent following the institution of bed rest. It is greatly increased by lugolization, or for that matter, by any form or iodine medication. Following subtotal thyroidectomy, there occurs an immediate fall in the blood iodine. The blood iodine remains irregularly high so long as postoperative iodinization is continued. Following the cessation of postoperative iodinization, it falls to a low normal level if an adequate thyroidectomy has been made. If an adequate thyroidectomy is not made, or between the two stages of a two-stage lobectomy, the blood iodine remains elevated. This is further evidence of a continued hyperthyroidism.

The urinary excretion of iodine is increased in patients with hyperthyroidism. This is particularly to be noted in the early exacerbation of untreated toxicity in patients with diffuse hyperplastic goiter accompanied by severe hyperthyroidism. It is increased in patients with toxic nodular goiter. There is a marked rise in the excretion of iodine following thyroidectomy. Following an adequate thyroidectomy there is an eventual decrease in the urinary excretion of iodine.

The iodine content of the diffuse hyperplastic goiter of Graves' disease is low[9]. It is greatly increased by any form of iodine administration. The iodine content of toxic nodular goiter is variable. In general, it is low, although certain of the colloid nodules may have a high iodine content[9]. In "mixed goiters" the diffuse hyperplastic portion contains a high iodine content subsequent to previous iodinization.

It is not yet possible to put the use of iodine in the management of hyperthyroidism upon an entirely rational basis. One of the empiricisms, however, which has given way, is that a specific form of iodine is necessary. It is possible to prepare patients adequately with various forms of iodine. The amount of iodine ordinarily administered is, doubtless, too great. There is no available evidence that larger amounts of iodine produce any difference in the ultimate effect. Our metabolic studies indicate that smaller amounts are quite adequate, since we find the excess amount rapidly excreted in the urine.

It is now quite within the realm of possibility to establish the iodine management of hyperthyroidism upon a rational, rather than upon an empirical basis. This will involve further investigation. In this newer aspect of the management of hyperthyroidism lies hope of progress in the solution of the problem of toxic goiter.

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CLOSING DISCUSSION

BY DR. GEORGE M. CURTIS

The question has been asked me:, Will it ever be practical for the general practitioner to determine the iodine content of the blood and urine?

I may, perhaps, best answer this question by telling you of our experience. I became familiar with this method in Switzerland in 1925. At that time von Fellenberg was making blood and urinary iodine analyses. Upon returning to Chicago, it soon became evident that this was not a clinical method, but rather one for a competent chemist. As a consequence, through Professor Fred Koch, we obtained the services of Dr. Chester Davis, a trained biochemist. Dr. Davis spent five months working on the method before it was ready to apply to the blood of patients. In his hands the method was successful. Others who have tried to use his method have had difficulties.

During the past year, Mr. Francis Phillips has made certain important modifications in the method, so that it is now nearer feasibility of application in the clinical laboratory. We have tried for over a year to make it a clinical method. We have not yet succeeded. At present it is a research method. It may be possible, eventually, to make it applicable for the clinical laboratory. It is possible that other methods will be devised which will supersede this detailed chemical analysis. The main difficulty of our method of analysis is in keeping the iodine during the ashing process. Per-

haps a polariscopic method may be devised, or a spectrophotometric method. Such have already been proposed in the literature.

While the method is not yet ready for general clinical use, its research value is tremendous, as it gives us opportunity to study thoroughly iodine metabolism in its relation to thyroid disease, and particularly to hyperthyroidism.

At this time, may I emphasize two practical features of our work. It is doubtless true that we use too much iodine in preparing patients with hyperthyroidism for thyroidectomy, or in the medical treatment of hyperthyroidism. Thirty minims of Lugol's solution contains 226 mg. of iodine. The entire human body contains but about 50 mg. As a consequence of our investigations, we have frequently prepared patients for thyroidectomy, using only 10 mg. a day. Our series is small. However, so far as I am able to judge, our results with small doses are as good as those in which we have used the larger amounts.

The other point is regarding the form in which iodine is administered. It makes little difference what form of iodine is used in the treatment of patients with goiter, or in preparing patients with hyperthyroidism for thyroidectomy. We have used a lipiodine. I notice that diiodotyrosine has recently been used. We have found that any form of iodine medication raises the iodine content of the blood. Consequently, this iodine is available to the thyroid gland, and, may we add, to the tissues.

A STATISTICAL STUDY OF PEPTIC ULCER

By M. E. BLAHD, M.D.,
CLEVELAND, OHIO

IT IS now approximately twenty years since roentgenological technique was developed to the point where it became possible to diagnose precisely and to check accurately the progress of peptic ulcer. Since prior to that time there were no means definitely to recognize its presence or to determine its improvement under treatment, a correct evaluation of the ulcer problem must necessarily then confine itself to this twenty-year period.

Accumulated experience of that period permits the following definite conclusions:

1. That the etiology of ulcer is still undetermined.

2. That certain ulcers have a tendency to cure themselves spontaneously.

3. That superficial, uncomplicated ulcers can be permanently healed by medical treatment.

4. That calloused, penetrating ulcers are, for the most part, refractory to medical treatment, and that medical treatment in this type of ulcer is distinctly dangerous.

5. That surgery, in the form of subtotal gastrectomy, offers the best chance of a safe and permanent cure in the penetrating type of ulcer, either complicated or uncomplicated.

Contrary to the progress recorded in the treatment and diagnosis of peptic ulcer, the last twenty years has produced very little to clarify the etiology. The same controversial ideas which existed at the beginning of the century still exist today, the only difference being the addition of more ideas to still further confuse the situation. Boyd in his surgical pathology states, "That a gastric ulcer arises from the same type of lesion as precedes ulcer in other parts of the body, but it owes its peculiar appearance, in which it differs from all other ulcers, to the action of the gastric juice. Moreover, a comparatively trivial lesion, which in the skin would never develop into a sore, will rapidly become converted into an ulcer in the stomach, owing to this same digestive action". This I believe is the simplest and sanest explanation of this subject.

Undoubtedly any one of the many factors operative in the stomach may cause an area of lessened resistance, and thereby prepare the field for the erosion of the otherwise acid-resisting mucosa. Infection gastritis, Ottfried Mueller's neuro-diathesis, trauma, capillary thrombosis, heredity, ulcer predisposition, etc., all play a part, but none of these acting independently of the gastric secretions can cause peptic ulcer. The belief that the acid plays the chief role has been greatly strengthened by Mann's experiments, in which chronic peptic ulcers were routinely produced in dogs by diverting the alkalinizing mechanism of the duodenum into the colon. The acid theory is still further enhanced by the finding of typical chronic peptic ulcer in Meckel's diverticuli. Microscopically these diverticuli contained gastric mucosa secreting hydrochloric acid. In summing up this mooted question I cannot help feeling that in searching for the cause of these stubborn ulcers we have strayed too far afield, that actually the cause lies close at hand and that the gastric secretions are a most important factor.

THE MEDICAL TREATMENT

To speak in general terms, medical treatment attempts to place the stomach at rest, and by frequent feedings to keep the hydrochloric acid in innocuous combination. Any excess is neutralized by alkalies, or to obviate the use of alkalies, diets rich in carbohydrates are employed to prevent excessive secretion. Antispasmodics and sedatives are given as needed. In this fashion

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it is hoped to bring about a healing of the ulcer and to prevent a recrudescence of the symptoms.

It is generally believed that medical treatment of peptic ulcer is entirely safe, and that it is free from the dangers which complicate the surgical treatment. Even the medical profession has allowed itself to be deceived in this direction, and most certainly the laity believes firmly in this false assumption. Consideration of a few statistics will reveal that this belief is contrary to the facts.

Blummer of Birmingham records 67 deaths in 526 cases treated medically. Crohn, 4 deaths in 94; Franklin White, 4 deaths in 204; in 1897, Laube, without stating the number of cases, recorded a 2.4 per cent mortality.

Even this admitted mortality does not tell the entire story. Deaths caused by perforation during active medical treatment are charged to the surgeon rather than to the internist. This is also true of the occasional death due to hemorrhage. It is not, as is commonly supposed, the *acute* ulcers which perforate, but, quite on the contrary, the *chronic* ones, those which are undergoing, or have undergone, frequent and prolonged medical treatments.

In 178 fatal cases of perforated peptic ulcers, Moynihan and Stewart report 13 acute, 165 chronic. At Mount Sinai Hospital of Cleveland, in a series of 47 cases of perforation there were 27 chronic and 5 acute; 15 were not classified, since the operative notes do not clearly describe the pathology. It is certain, however, that many of these 15 unclassified cases were chronic, since most of the patients presented digestive symptoms of many years' duration.

Even in view of the sparsity of figures recording the medical death rate, it is permissible to conclude that medical treatment is fraught with dangers, and has a definte mortality.

Looking over the results obtained by the medical treatment, we find the immediate results exceptionally good, the remote ones less encouraging. One of my patients, who had for many years received medical treatment for a duodenal ulcer, expressed this fact very aptly when he remarked, "It is easy to cure my ulcer, but to keep it cured is a different story."

The following brief statistics attest the accuracy of the above statement:

Nielson reports:

60 per cent cured and 17 per cent better after 6 months								
54	"	"	"	17	"	"	"	" ½ to 1 year
37	"	"	"	21	"	"	"	" 1 to 3 years
20	"	"	"	27	"	"	"	" 3 to 5 years
11	"	"	"	27	"	"	"	" 5 to 10 years
5.3	"	"	"	17.6	"	"	"	" over 10 years

Of 41 cases followed for five years, Forman reports 22 per cent as well; 20 per cent as better. Einhorn and Crohn, presenting the results of a careful follow up of 100 cases, report 67.5 per cent cured, and 22 per cent better after one year. Four years later only 22 per cent cured and 23 per cent better. Franklin White and Barford give similar results. R. Hutchison, commenting on the White and Barford series, makes the following statement: "Considering that these results were obtained in private patients, treated under the best conditions, they must be regarded as disappointing."

It has been recently pointed out that these recurrences may be due to the persistence of the gastritis or duodenitis and not to a reactivation of the ulcer. Even if this statement is true, and it probably is, it only serves as further evidence of the inability of medical treatment to secure permanent results in complicated cases. A. Rendle Short after an exhaustive study of the medical treatment arrives at the following conclusions:

"That given the best medical treatment, three out of four cases of gastric and duodenal ulcer, probably more, will become symptom free. Only 40 per cent of the patients will remain well, and from 15 to 19 per cent will be dead in about ten years. Early cases do well, long standing cases do badly."

Progress in the therapy of peptic ulcer has been retarded by the lack of definite indications for the several forms of treatment. The obsolete anatomical classification dividing peptic ulcer into the gastric and duodenal type, has, in my opinion, been responsible for this lack of progress. As far as the treatment is concerned, it is irrelevant whether the ulcer is situated to the left or to the right of the pylorus, but, on the other hand, whether the ulcer is superficial, penetrating, or perforated makes a world of difference.

It is quite obvious that simple, superficial, acute ulcers which can be healed medically, will not require as energetic or radical treatment as the complicated ones. Accordingly, it can no longer be considered good practice to subject every ulcer routinely to prolonged and repeated medical cures before employing surgery. If the ulcer is superficial, thorough medical treatment should be tried; if it is of the calloused, penetrating type, the chances for a medical cure are so remote that surgery should be resorted to at once and the danger of perforation and hemorrhage be thereby avoided. Boas, of Berlin, in a recent address made the following statement: "At the risk of being considered more surgical than the surgeon, I am of the opinion that not the number of medical cures, but rather the kind and character of the ulcer should determine the surgical indications."

In the introduction to this article, it was said that in the penetrating, calloused type of ulcer, subtotal gastrectomy offers the best chance of a safe and complete cure. There are, however, still so many experienced workers in this field who disagree with this statement, and who still believe in gastroenterostomy, that it would be obviously unfair to dismiss gastroenterostomy from consideration without first stating its pros and cons in comparison to subtotal gastrectomy. The adherents of gastroenterostomy claim that it will permanently cure 85 to 90 per cent of all peptic ulcers, with a death rate not in excess of ½ to 4 per

cent. These results, they say, are equally as good as those obtained with the more mutilating and dangerous subtotal gastrectomy. If such brilliant results as set forth by the gastroenterostomists could be uniformly obtained by all surgeons, there would be no need of discussing or employing any other type of operation. But the very fact that there is so much discussion of other operations gives evidence that all is not well in the case for gastroenterostomy. The following statistics relating to the cure of peptic ulcer with gastroenterostomy are random selections from the literature, with the two exceptions of the figures emanating from the Mayo Clinic, and from Sherren's Clinic in London, which were purposely included, since these clinics are the leading exponents of the indirect method. A total of 5572 carefully followed up cases were studied:

	No. Cases	No. Cures	% Cures
R. Wanke, Germany	179	93	52.5
Hans Lehman, Germany	93	67	72
R. Lewisohn, U.S.A.	68	34	50
T. Roseving	64	49	76.4
J. Hohlbaum, Germany	32	18	56.2
A. Horwitz, Germany	17	11	64.7
P. Claremont	289	162	56
Kalin	70	33	47
Schmieden	250	125	50
De Takats	270	135	50
Mayo Clinic	1,000	880	88
Patterson	447	349	78
Solkov & Iljun	580	412	69.3
Sawkoff	327	226	69
Schwartz	200	100	50
Coffey	305	223	73.1
Fremont Smith & McIver	412	277	67.2
Sherren	500	450	90
Johns Hopkins	96	54	56
Metraux	210	189	90
Gatewood	163	109	66.8
	5,572	3,996	71.7

Of these 5,572 cases, 3,996, or 71.7 per cent were reported as cures and partially satisfactory results. The percentages range from 90 per cent of cures obtained by the Sherren Clinic and Metraux to 50 per cent obtained by Schmieden, Lewisohn, Schwartz, De Takats, and 47 per cent by Kalin. This wide discrepancy is difficult to understand, and no attempt will be made to offer an explanation. This fact, however, is clearly demonstrated—that uniformly good results are not obtained with the indirect method, and that at least 28 per cent of such operations completely fail to cure peptic ulcer.

The most striking information obtained from the foregoing figures is the wide divergence in the percentage of cures (from 47 to 90 per cent). It becomes all the more striking when the fact is taken into consideration that the above results were obtained in Class A clinics by competent surgeons using similar methods and similar technique.

The analysis of the statistics of the *resection method* gives an entirely different picture. Here in contrast to the statistics on gastroenterostomy, the figures show a striking unanimity of results. The percentage of cures ranges from 82 to 98. Included in these statistics are those of Von Haberer, Moynihan, Finsterer, Strauss, Berg, and others. In the writer's own series of 138 cases, carefully followed by numerous personal contacts with the patients, the cures so far are upwards of 90 per cent. Before leaving the subject of cures, it might be well to mention the fact that following the resection method, no dietary regimen is necessary, whereas on the other hand, the advocates of gastroenterostomy insist upon continuous diet even after operation. This in itself is a paradox, for if gastroenterostomy had cured these patients, why the necessity of further diet?

MORTALITY RATE

The next consideration, the mortality figures of these two operative types, can best be served by studying the death rate of large series of cases as reported by the leading exponents of the two methods. For this purpose the writer has selected 2,193 gastroenterostomies performed for both duodenal and gastric ulcer at the Mayo Clinic, and 3,122 partial gastric resections performed for the same illness at various clinics throughout the world.

The Mayo series gave an immediate mortality from all causes of 4.5 per cent in 545 cases of gastric ulcer, and 2 per cent in 1,648 cases of duodenal ulcer, a combined mortality of 2.6 per cent.

In 3,122 cases of gastric resection collected from 16 different clinics, there was a mortality of 5.76 per cent.

On the surface it appears that the death rate of gastroenterostomy is somewhat less than that of resection, but only a slight scratching of the surface suffices to show the fallacy of this impression. Although the operative mortality for 2,193 gastroenterostomies was only 3.25 per cent, there was an added mortality from all causes of 10.75 per cent in an average postoperative period of 3.6 years. How many of these fatalities were due to ulcer disease is not stated in the report. It is, however, fair to assume that a certain percentage of these individuals required secondary operation for either recurrent ulcer, jejunal ulcer, vicious circle, hemorrhage, or perforation. That such secondary operations entail an immensely higher mortality is an established fact. According to Claremont, secondary operations have a death rate twice as great as primary operations, and in the case of jejunal ulcer, perforation, and hemorrhage, this may reach five to six times the initial rate.

When this high secondary mortality is added to the initial death rate it is evident that the mortality of gastroenterostomy is considerably higher than is generally supposed. The many reports at hand conclusively demonstrate that such complications as mentioned above are only very rarely

observed following the more extensive operation. *Secondary mortality following the resection method is practically nil.* In his own series, the author has seen not a remote complication following the resection method which was either directly or indirectly attributable to the original ulcer. Without this high secondary mortality the death rate of the resection operation is certainly not higher than that of gastroenterostomy; if anything, it is considerably lower. That the immediate mortality of resection is capable of further reduction is proved by the fact that Van Haberer was able to operate 99 consecutive cases without a death, Gatewood 30, and the author, 37.

In leaning backwards in an effort to be fair to the adherents of gastroenterostomy, I have used the figures emanating from the Mayo Clinic as a standard for the mortality rate. Not all clinics have been able to match these statistics. Moynihan, analyzing the 2,052 cases collected by the British Ulcer Commission in England (Short), records an immediate mortality of 5.7 per cent, ½ per cent higher than that which obtains in the resection method.

Figures of the British Ulcer Commission:

995 duodenal ulcers	50 deaths	5 %	mortality
454 pyloric ulcers	12 deaths	3.6%	mortality
538 gastric ulcers	48 deaths	8.9%	mortality
65 hour glass	8 deaths	12.3%	mortality
2,052	118	5.7%	

Jejunal ulcer, a condition unknown before the advent of gastroenterostomy, has been variously estimated as occurring in anywhere from 5 to 30 per cent of gastroenterostomies (Von Haberer, Finsterer, Strauss, Myer). That the frequency of this condition is generally underestimated is borne out by the fact that four such cases came under the writer's personal observation in the short period of two years. The etiology of this condition, as that of peptic ulcer in general, is still considerably in doubt. Nevertheless, its almost complete absence following the resection method gives rise to the thought that hydrochloric acid must play a very important role in the causation of this type of ulcer. Several isolated instances of jejunal ulcer have been reported following the Billroth 2 operation. It is quite possible, however, that these were due to an incomplete resection. Following the Billroth 1, there is not a single authentic case (personal communication to the author from Von Haberer).

As for the claim of pernicious anemia following the resection method, suffice it to say that literature records only 17 such cases, in some of which it appears that the diagnosis has not been clearly established. When this small series is compared to thousands of recorded cases of subtotal gastrectomy, of more than five years duration, this alleged source of danger shrinks almost to the vanishing point.

In closing, I wish to reiterate my opening statement that simple, superficial, uncomplicated ulcers can be healed by medical treatment, but that surgery, in the form of subtotal gastrectomy, offers the best chance of a safe and permanent cure to the patient suffering from the penetrating type of ulcer.

1420 MEDICAL ARTS BLDG.

VAGARIES OF VENOUS THROMBOSIS

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MEDICAL literature contains many articles and case reports dealing with the subject of post-operative emboli. The frequent occurrence of unexpected signs and symptoms from thrombosed veins and their by-products, unassociated with surgical procedure, has not received the attention it merits. The list of cases from our own records seems to justify the term vagaries, because they present a variety of etiologic factors and some unusual symptoms.

A general impression exists that the number of pulmonary complications following surgery is on the increase. Perhaps this is due to the newer types of anesthesia, which produce profound relaxation, thus resulting in slowing of the blood stream. Infection, trauma and alteration of the physiology of blood clotting may be contributory causes, but slowing of the circulation appears to be the one constant factor necessary to permit a vein to be thrombosed.

During the past twelve years in the Youngstown Hospital there have been 201 cases in which some condition involving the veins was included in the final diagnosis. Seventy-two, or 35.5 per cent of this group had evidence of a pulmonary complication. In several cases in which the source of the pulmonary embolus was later discovered, a provisional diagnosis of pneumonia had been made. A very careful analysis of the history and a meticulous study of the manner of onset was more important than physical findings in bringing about the change in diagnosis from pneumonia to pulmonary embolism. The chief error was failing to consider both pneumonia and pulmonary embolism as possibilities. The most constant sign of pulmonary embolism was the abruptness of the onset. The absence of blood spitting cannot be safely taken as evidence against embolism, for this sign occurs in less than half of the cases.

Axel Oure warns against trying to be too definite about the physical signs in the lung when em-

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bolism is suspected.[1] We believe with him that such patients should be kept quiet and not asked to breathe deeply. It is safer to ask the aid of the roentgenologist.

There is a tradition inherited from the pathologists that an area of infarction in the lung is wedge shaped. This is often demonstrable at autopsy, but the finding of such a classical lesion by *X*-ray studies should not be expected. It is extremely rare in our experience. There is more often a localized haziness of an airless area with evidence of pneumonitis about it. The following brief case report will serve to illustrate the importance of *X*-ray help in diagnosis:

On the fourth post-operative day, in a young man who had his right kidney removed, there was a shower of pulmonary emboli. The signs and symptoms could have been produced by any one of three conditions—(a) pneumonia, because of the great degree of lung infiltration; (b) multiple lung emboli, which seemed most likely because of abrupt onset; (c) post-operative massive collapse of the lung. This latter possibility was considered particularly because of the fact that the patient splinted the muscles on the side of the abdominal incision, producing a relatively inactive right chest.

As in the above instance, so it was in seventeen others, that post-operative pulmonary atelectasis offered a problem in diagnosis. Inasmuch as massive collapse of the lung usually occurs within twenty-four hours post-operative, differential diagnosis from pulmonary embolism is not exceedingly difficult, for this is almost always after the first week. However, pneumonia may arise within twenty-four hours of operation and is more likely to be confused with atelectasis. In the typical case massive collapse occurring after anaesthesia is marked by sudden onset within twenty-four hours of operation. There is a rapid rise of pulse and respiratory rate. The patient looks shocked, is usually pale, wants to sit up to breathe or chooses to lie on the collapsed side. Because of the lessened volume of the lung on the affected side the heart and mediastial tissues are displaced in that direction. There are a great variety of auscultatory signs, especially in the less severe cases, so inconstant and varied that, although the diagnosis should be suspected, it is unsafe to make a positive statement on these findings alone. Lessened excursion of the affected side with widened interspaces and restricted activity of the diaphragm is sometimes seen. In evaluating these signs the alteration of respiratory physiology produced by the surgical incision must be kept in mind. The therapeutic test of rolling the patient from side to side or of giving C.O.[2] inhalations may be tried cautiously. Occasionally this permits access of air to the collapsed lung and makes the diagnosis apparent by relieving the obstruction in the bronchi. For the reason that there may be varying degrees of atelectasis, except in cases with classical signs, it is safer to depend upon fluoroscopic and *X*-ray film studies to establish the differential diagnosis. Bronchoscopic drainage is the quickest and surest treatment and may be an adjunct to diagnosis.

Apart from post-operative venous thrombosis with the complications arising therefrom, there are numerous causes of venous blocking. Of these, traumatic thrombi, although very common, may produce emboli so long after the original injury that the source may have been forgotten.

Inflammation of a vein arising during the course of an infectious disease, especially in typhoid fever, is anticipated. Strangely enough, emboli rarely break loose from typhoid phlebitis. In a case listed by us in 1921[2] there was proptosis of the left eye ball due to venous thrombosis, and yet no evidence of emboli. These experiences suggest that infection is not an all important factor in the production of emboli.

Other diseases in which venous thrombosis is common are pneumonia, influenza and acute rheumatic fever. It occurs less frequently in erysipelas, diphtheria, smallpox, measles, tonsillitis and scarlet fever. Occasionally chronic tuberculosis is accompanied by evidence of venous thrombosis. Severe chlorosis is complicated by thrombi in the veins in about 2 per cent of the cases.[3]

Pelvic thrombi associated with labor and the puerperium producing phlegmasia alba dolens has long been recognized as a source of discomfort, disability and not infrequently fatal results in those affected. We have seen in two instances pulmonary embolism following the routine procedure of having the patient assume the knee chest position ten days post partem.

Thrombosis of the lateral and cavernous sinuses are frequent complications of mastoid and nasal assessory diseases. The invasion of these structures is by contiguity.

Case reports of many of the usual types of venous thrombosis are abundant, but the pathological museums of our medical schools contain relatively few specimens, owing to the fact that thrombi are fragile and do not keep well. To emphasize the surprising variety of pathologic findings, a few specimens will be described.

Of several museums visited since becoming interested in this subject the collection of Dr. Oscar Klotz at the University of Toronto was found to be the most complete. Klotz' solution preserves thrombi very satisfactorily. There is one specimen in this collection showing thrombosis of the jugular, subclavian and inominate veins, a condition similar to one included in this report.

At the Royal Victoria Hospital in Montreal, perfectly preserved, is a specimen of thrombosis of a vein of the meninges of the lumbar cord.

Through the courtesy of Dr. B. W. Roberts of Durham, N. C., I am permitted to mention two cases which have not yet been published. Identical twins, age fifteen months, died within a week of each other and at autopsy, in both instances,

pulmonary emboli proved to be the cause of death. No assignable cause could be stated.

Lewis Conner describes a queer case of recurrent thrombo phlebitis each time his patient ate shell fish.

The ten much abbreviated case reports which follow illustrate a few of the wide variety of causes of thrombosed veins and the symptoms which may follow.

CASE REPORTS

CASE 1—W. L. C., male, age 54, whose first symptom was pain in the left chest. The original diagnosis of pneumonia was corrected to infarction in the left lung. The source of the infarction was difficult to determine until the patient recalled that there had been an injury, not disabling, to the left leg while playing baseball two months previously. The local manifestations of past injury at the time of infarction were so trivial that only after a careful survey of possibilities could a very slight tenderness just above the left knee be elicited. *X*-ray study showed haziness in the base of the left lung at the site of the physical findings of consolidation. Three days later death occurred suddenly. Autopsy revealed an occlusion of the entire left femoral vein. Both branches of the pulmonary artery were closed by a large embolus. There was a healing infarct in the base of the left lung, as shown by *X*-ray. The establishment of an accidental cause of death was important from an insurance standpoint, as it involved the payment of a thirty-thousand dollar claim.

CASE 2—Mrs. G., age 52, had three injections for the purpose of occluding varicose veins in the leg. Shortly after the third injection evidences of pulmonary infarction developed. A few weeks later another embolus floated free and lodged in the right lung. Four days later the unusual experience of hearing an embolus pass through the heart was recorded.[4] The patient died within forty-eight hours.

CASE 3—Mrs. G. L., age 56, had suffered from chronic edema of the legs due to varicose veins. She had three attacks of so-called pneumonia within four months. The last one was definitely thought to be due to an embolus, the embolus having dislodged itself from the veins in the right calf. In order to prevent the possibility of fatal embolus, the long saphenous vein on the right side was tied off. The patient has had no recurrence of lung symptoms since that time (1931).

CASE 4—J. W., male, colored, age 44, was admitted to the charity ward with diagnosis of starvation and constipation. Just after receiving an enema the patient fell over in a faint. He soon rallied, but complained of severe pain in the chest, over the base of the right lung where signs of consolidation developed, leading to diagnosis of pulmonary embolism. The *X*-ray film shows a large area of haziness at the base of the right lung. There was blood spitting the next day after onset of symptoms. The source of the embolus was thought to be the veins about the rectum. one of which was found to be definitely thickened.

CASE 5—Mrs. B. D., age 39, within a few minutes after an intravenous injection of neosalversan had pain in her left chest. This soon became so severe that she could scarcely breathe. The pain then extended into the right chest and evidences of circulatory collapse supervened. Within a few hours the temperature was elevated, reaching 102 on the third day. Signs of consolidation appeared at the base of the left lung. The patient coughed but had no sanguinous sputum. There was gradual improvement with rapid recovery after the fourth day. *X*-ray studies showed infiltration at the right base, most likely due to pulmonary infarction.

CASE 6—Two hours after normal delivery a primipara was seized with sudden pain in her chest. She became cyanotic, coughed almost continuously, and developed signs of pulmonary edema. The temperature reached 100, subsided in two days. She left the hospital well on the fourteenth day post-partum. Multiple pulmonary emboli found by *X*-ray study.

CASE 7—Mrs. B. F., age 45, during a period of decompensation from mitral stenosis had thrombosis of the left external, jugular and subclavian veins. There was marked tenderness and edema of the left side of the neck and the entire left arm. Physical signs in the upper chest suggested that the deeper veins were also affected. The patient lived one year after signs of venous thrombosis had disappared. In the museum of the University of Toronto in the Banting Laboratory there is a pathological specimen showing this identical condition.

CASE 8—On the fourteenth day after hysterectomy for uterine fibroid a colored woman, age 38, died suddenly.Her temperature had not been normal since operation. There was marked venous thrombosis in the liver, a large pulmonary embolus and a tremendous antemorten clot caught in the heart.

CASE 9—A colored woman in her early thirties was admitted in coma. She had been in the ward over night five weeks previously for the treatment of a stab wound in her left arm which had healed perfectly. For about three weeks she had suffered much abdominal distress and pain and had vomited almost continuously. The day before admission she had complained of extremely severe headache and progressive sleepiness which developed into coma. Her temperature was 104, later rising to 106. The leucocyte count was 29,000. Signs of severe involvement of the central nervous system were present. The abdominal physical examination was not remarkable. Death occurred on the third hospital day. Autopsy revealed a thrombosis of the portal vein extending into the splenic and superior mesenteric veins. There was gangrene of twenty inches of the ileum. A large obstructing clot was found in the circle of Willis. The diagnosis was septicemia. It is needless to state that this wide variety of pathologic changes was not suspected.

CASE 10—R. W., age eight and one-half, had concomitant scarlet fever and diphtheria. Massive subcutaneous hemorrhages developed, resulting in skin necrosis. Signs of occlusion of the inferior vena cava followed. The patient had several blood transfusions and repeated skin grafting. He recovered, but has varicose ulcers. He is now a premedical student.[5]

SUMMARY

1. Emboli commonly occur after surgery but many other causes of venous thrombosis are important and may be obscure.
2. Pulmonary complications occurred in 35.5 per

cent of 201 cases in which pathology of the veins was listed on the final diagnosis.

3. Certain points are stressed in the differential diagnosis of pneumonia, post-operative massive collapse and pulmonary embolism.
4. Several pathologic specimens are described to show the wide variety of structures which may be affected by thrombosis of the veins and a list of diseases in which the condition may occur is given. (Lantern slides.)
5. Several brief case reports are included to illustrate the following various causes of venous thrombosis
   1. Trauma.
   2. Scarlet fever.
   3. Injection for the purpose of occluding varicose veins.
   4. Normal delivery.
   5. Intravenous medication.
   6. Septicemia.
   7. Mitral stenosis, cardiac decompensation.
   8. Simple enema releasing hemorrhoidal thrombosis.
   9. Unusual post-operative cases
      - A. Multiple pulmonary emboli simulating pneumonia and post-operative massive collapse.
      - B. Emboli of liver, lung and heart after hysterectomy for fibroid uterus.

In this brief presentation no attempt has been made to cover the entire field of venous thrombosis. Personal experiences, hospital records and reviews have been used to direct your attention to the protean manifestations of the important medical problem.

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A COUNTY PLAN . . . FOR THE CONTROL OF TUBERCULOSIS

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INITIAL efforts to control tuberculosis as a communicable disease were begun about forty years ago. No other disease has had the equivalent amount of scientific and sociological research, nor the expenditure of as much energy and money by governmental and community agencies. In this time tuberculosis has dropped from first to seventh place as a cause of death, and the incidence of pulmonary tuberculosis has sharply decreased. There are many authorities who believe that this decrease in its mortality and morbidity rates has been due to the gradual rise in our standard of living. However, there has not been a rise in the mortality and morbidity rates coincident with the lowering of economic standards during the past three years of depression.

TUBERCULOSIS A MAJOR PUBLIC HEALTH PROBLEM

In spite of forty years of intensive effort to control tuberculosis and the resultant decrease in its mortality and morbidity rates, it remains one of the major problems of public health. Up to the age of fifteen years, death from tuberculosis is more frequent than death from any of the other communicable diseases. Between the ages of fifteen and forty years tuberculosis is a more frequent cause of death than any other single disease.

It is recognized that social and economic conditions greatly affect the occurrence of the disease, and it has been aptly said that poverty and tuberculosis go hand in hand. Tuberculosis is therefore a social and public health problem as well as a medical one. Every phase of community life which improves the individual and community welfare helps to prevent and control the disease. Public health, sanitation, supervision of food and milk supply, abolition of over-crowding in the home, improved working conditions, shorter hours of labor, better wages, public parks and playgrounds, medical supervision in the schools, and many other community activities—all play an important role.

The prevalence and virulence of tuberculosis in the negro has created a serious public health problem since he has become widely diffused throughout our population. Intensive attention is necessary to control this prolific source of infection and re-infection.

Another source of infection in Summit County is the large number of our people from the

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Springfield Lake Sanatorium.

secluded mountain regions of West Virginia, Kentucky, and Tennessee who have come to Akron in the past ten to fifteen years. They have the low resistance to the disease which is characteristic of people of pure basic stock.

Still another problem is created by the fact that a majority of patients have advanced disease at the time it is discovered. They need prompt treatment as the prognosis is unfavorable, but the sanatoria are filled and already have long waiting lists. This necessitates an indefinite period of home treatment, and the burden of their care is upon the public health nurses. They receive little or no medical supervision, and their families, particularly the children, are further exposed to the disease.

A striking illustration of the danger in such cases was shown in a family consisting of mother, father, and seven children. The mother, a far advanced case, waited several months at home before she was admitted to the sanatorium. During this period five of the children under fifteen years of age, who previously had shown no disease, developed pulmonary tuberculosis. There were then five patients to treat instead of one. The mother died shortly after she was admitted and two of the children have progressive lesions and are at present at the sanatorium under treatment.

FUNDAMENTAL ELEMENTS

There are certain fundamental elements directly concerned with the control of tuberculosis:

I. Legislation which requires physicians and institutions to report tuberculosis.

II. Legislation to supervise the food and milk supplies of the community.

III. A properly organized and adequately financed health department which either has a bureau of tuberculosis or engages in this work as a major activity.

IV. Sanatoria built, equipped, and managed according to the standards of the American Sanatorium Association.

V. Provision for the segregation of chronic or dangerous cases.

VI. Well-managed diagnostic clinics, which should be equipped with *X*-ray apparatus for diagnosis or else have such a service available.

VII. A preventorium or open window rooms in the schools.

VIII. An adequate number of tuberculosis nurses.

IX. Full-time physicians who engage in the work of the Sanatorium, clinics, and home. A medical director should guide and coordinate these activities with those of the health department and public health nurses, advise with the school physician, and serve as a consultant to private physicians.

THE UNIT FOR THE CONTROL

The state and its various political subdivisions, district, county, city, and town have been used as a basis for the development of both official and non-official organizations to combat tuberculosis.

The original organizations developed in large cities, and, as a rule, they have been most efficient and successful. But where the city has a sanatorium, hospitals, and well-developed clinics and public health nurses the township and rural districts around them frequently have none or the work is inadequately or loosely organized.

Other official programs have been organized upon a state-wide basis. The sanatoria, clinics, and field work are managed through a tuberculosis bureau of the State Department of Health. The difficulty with this type of organization is that the control of tuberculosis is a local community problem; it needs intensive and continuous effort of all the local agencies, and the state is too unwieldy a unit to coordinate the various activities, particularly in metropolitan centers.

The State Health Department, as an official organization, and the State Tuberculosis Association, as a non-official organization, both render invaluable service by stimulating the development of tuberculosis work in the various communities and by acting in an advisory capacity to improve the character of the work.

It is now conceded by most authorities that the county is the most efficient unit for the administrative control of tuberculosis. While we believe that the county is the logical unit in the control of tuberculosis, and the unit most adaptable to varying local conditions, we do not recommend that the counties in sparsely populated sections be individually straddled with sanatoria. Both efficiency and economy argue against this. By grouping together two, three, or more neighboring counties into a district unit for control, a larger, more adequately financed, and more efficient sanatorium and medical staff is provided and at less cost to the taxpayer, since it obviates unnecessary reduplication.

The cornerstone of the county unit of control is the sanatorium and its full-time medical director. His duties at the sanatorium, and the care of its patients, comprise but a small part of his obligations. It is therefore necessary that he have an adequate full-time medical staff to assist him in the routine sanatorium and outside duties. New York City was the first to adopt a comprehensive plan to control tuberculosis and passed stringent laws to enforce segregation. But in May, 1926, with 26,053 registered cases of tuberculosis, the health authorities had placed only 6,634 of these cases in institutions. It is obvious that it is impracticable to segregate all cases of tuberculosis in sanatoria. The expenditure is unwarranted and insupportable.

Admirable as have been the results of sanatorium treatment in reducing the mortality rate of tuberculosis, it is evident that this is not checking or controlling the disease in the community. After years of failure to bring even a fair proportion of the incipient cases of pulmonary tuberculosis to light, it is evident that something has been wrong with our approach to the problem.

The control of pulmonary tuberculosis resolves itself into two distinct phases. The first is to ferret out every case as early as possible, preferably while it is in the incipient stage and the sputum is negative. This is important because most new cases are the result of contact with developed cases. The second phase is the management of the cases already discovered, so as to arrest the disease, rehabilitate the patient, and prevent the case from being a source of new infection.

The attempt to bring to light and properly manage patients with pulmonary tuberculosis depends upon cooperation. Cooperation between the sanatorium staff and private physicians throughout the county is the most essential. Since tuberculosis is most prevalent among the economically dependent classes, and since it is a disease which requires many months or years to arrest, most of the patients who are afflicted are dependent on county and charity funds for their care. They can not afford to have a private physician and in this respect differ from most of the patients who make up a physician's practice.

Private physicians should refer suspected cases to the tuberculosis clinics where facilities are available for *X*-rays which the patient could not otherwise afford. This will result in earlier diagnosis. The sanatorium staff is available to the private physician for consultation in the diagnosis and management of those of his patients who are able to pay for his services. The sanatorium staff must also be in close cooperation with the municipal and county health departments.

A clinic with facilities to take chest *X*-rays should be established in a central location. This is necessarily supported either by the city or county funds, or by some local civic organization. In Akron the tuberculosis clinic is maintained by the Federation of Women's Clubs and financed entirely by the annual sale of Christmas seals which they conduct. At the clinic cases of pulmonary disease are sifted out from a large number of suspects and contacts, and who are periodically examined and *X*-rayed. The medical examinations at the clinic are conducted by the sanatorium staff. Patients are referred to the clinic by private physicians, school physicians, industrial physicians, and by the tuberculosis nurses. Many attend of their own volition.

The tuberculosis nurse is one of the most essential of the groups used in this control organization. She is enrolled in the department of public health, and is fully occupied in the work of tuberculosis control. Her duties are to assist in the running of the clinic, to cooperate with the health department from the standpoint of tuberculosis, to visit and advise under the direction of the sanatorium staff those patients who are curing at home, to follow up and bring to the clinic families and neighbors who have been in contact with newly diagnosed cases, and to follow up those cases which have been examined previously and are considered suspicious. She will be in close cooperation with the school physician, and will follow closely all cases of childhood tuberculosis through adolescence and early adult life.

This close cooperation of physician, health department, and sanatorium staff is invaluable in discovering those having the disease and thus controlling the source. It will also result in an increased percentage of diagnoses while the disease is still in its incipient stage and so lighten the economic burden of the individual as well as the community.

The second phase of tuberculosis control is the treatment of those having the disease. The treatment of pulmonary tuberculosis has undergone a great change within recent years. Formerly it consisted of fresh air, good food, rest, tuberculin injections, and exercise. A maxim was prevalent that surgical operations were to be avoided. Exercise and tuberculin have been discontinued, the former as harmful and the latter as of little value. Rest, proper food, and fresh air have stood the test of time and remain the foundation upon which all other treatment is based.

Recently chest surgery has become an important adjunct in the treatment of tuberculosis and many patients who formerly were destined to chronic invalidism have been given a new prospect in life. In carefully selected cases, it helps to check the lesion, hastens healing, stabilizes healed lesions, and through the closure of cavities, permits a greater number to return to a gainful occupation. Chest surgery is an important factor in the prevention of the spread of infection. About 40 per cent more patients leave Springfield Lake Sanatorium with negative sputum since surgical measures have been adopted than formerly.

The sanatorium care of tuberculosis has clearly proved its value. A great majority of phthisiologists are convinced that treatment in the home can not be compared with treatment in the sanatorium, and all agree that a period of sanatorium treatment is invaluable as an educational measure. Rest is the foundation stone in the treatment of pulmonary tuberculosis. In some cases this may be properly followed in the home, in some cases the patient must have a period of education in the sanatorium so that home treatment is adequate, in some cases the treatment must necessarily be in a sanatorium. But if the patient is not in the sanatorium under the supervision of its staff, he must be under adequate medical and nursing supervision at home.

Home treatment of tuberculosis has never received wide approval in this country. There have been many failures, but it has rarely been given a thorough trial. This is the most neglected part of our anti-tuberculosis program. The patient usually can not afford private medical supervision, and when the sanatorium staff is not organized to render this service, he has only the guidance of

the public health nurse which is inadequate. J. H. Pratt in Boston and J. A. Miller at the Home Hospital in New York have successfully practiced home treatment for a number of years. Their final results compare favorably with the results of the best sanatoria in the country for the type of case treated, and in their experience no children in the home have developed the disease from contact to those patients under their care.

It has been our desire, not yet fulfilled, to develop a program of home treatment in Summit County. We would admit the patient to the sanatorium for a short period to control the lesion, get the sputum negative if possible, and educate the patient in the rudiments of the rest cure and the sanitary requirements to protect the family. The home conditions would be analyzed and where faulty corrected. When the patient returns home to continue the cure, he would be visited regularly by his private physician if he can afford his care, or by one of the sanatorium staff, the public health nurse, and the social worker if he is economically dependent. The object is to bring sanatorium treatment to the home and guide the lives of the whole household.

The home treatment merits development and organization for several reasons. As I have said, sanatoria facilities are not great enough to handle all cases of pulmonary tuberculosis. In many cases it is unwise for adult members of the family to enter the sanatorium, as it breaks up the family and deprives the children of the advantages of a home. In such cases a temporary expedient too often becomes permanent. Also many patients become so institutionalized during the sanatorium regimen that they never succeed in re-adjusting themselves when they do return home, and an irreparable damage results. This undesirable situation is obviated when the patient's lesion is of a type suitable for home treatment. A short period of education at the sanatorium will fit for home treatment those patients who do not do well while in the sanatorium because of worry and homesickness.

The need for the development of home treatment is obvious, but it must be founded upon a well-organized medical service and public health nursing service. However, its development will be hampered until the municipal and charity organizations provide the necessary financial support, involving in many cases a subsidy to the family to insure decent living quarters, food, and care. This cost would often be much less than the cost of supporting the patient in the sanatorium, aiding the rest of the family at home, or even caring for the children in a public institution, as is frequently necessary when one of the parents is removed from the home.

There is another need in this program of control. It is a nursing home, or other low-cost institution, offering a protected environment for those patients with chronic pulmonary tuberculosis who have reached a maximum of improvement and yet are not able to return to gainful employment or do not have a home to go to. Since most of these chronic cases have a positive sputum they can not go to the county infirmaries and should not be cast adrift in the community. As a result they take up valuable space in the sanatorium which is neither beneficial nor necessary for them.

The essential aim of this whole program is to extend and increase the usefulness and value of the sanatorium, to extend its services to all the cases of pulmonary tuberculosis in the county rather than restricting it to the few that can be admitted to the institution. The public receives a larger return for the money it provides.

One of the most difficult problems is the rehabilitation and placement of discharged patients. Schools for vocational training are maintained in some of the larger institutions. Formal classes are conducted in the various occupations to make the patient better qualified for his old occupation, or to train him for a new one. Such plans are impracticable for small institutions because few patients are ready for training at any one time and they present a wide diversity of education and capability.

Experiments with certain types of sheltered employment are being tried at the Altro Shops in New York, Iva Potts Memorial Hospital, Livingston, New York, and at Tomahawk Lake Camp in Wisconsin. The field for such enterprises is limited. There is no practical advantage to train handicraftsmen for the modern industrial community. Where industries are willing to cooperate, a patient with an average intelligence can be placed to a better advantage by the individual industry, than he could gain through a training in the manual arts. A poor handicraftsman will have a struggle to exist at his trade, a skilled one requires unusual ability and several years of training under masters.

Ours is an industrial community. The large manufactories, department stores, and public utilities have been taking an unusual interest in the welfare of their employees. They have placed many discharged patients in sheltered positions and allowed them to work part-time for a period of observation and until they could prove their ability to work the full day. The physicians and nurses in the industries have persistently encouraged suspects and discharged patients to go to the clinics for periodical examinations and they have been active in their efforts to secure prompt treatment for diagnosed cases. Those patients who are not able to resume or undertake some industrial occupation cause many problems. They are of the type which would cause problems under any plan for the rehabilitation of discharged patients.

THE CHILD

The future of tuberculosis control lies in the

protection of children for "the disease of tomorrow is recruited from the children infected today."

Rathburn found that from 3 to 4 per cent of the school population have childhood type tuberculosis and this group furnishes about one-half of the cases of pulmonary tuberculosis which develops before the twentieth year. When childhood type tuberculosis is found the family should be examined, because this will frequently reveal that the infection arose from a chronic pulmonary tuberculosis in adult members of the family previously unsuspected.

Rathburn believes, as do many others, that most children are infected in their homes. Annual medical examination and tuberculin testing of children through the school and college years, with the periodic *X*-ray examination of those reacting to tuberculin, is a most effective means of disclosing pulmonary tuberculosis in its incipient stage.

Children who are examined for tuberculosis are classified into the following groups: observation, suspicious, and childhood type tuberculosis. The decision of the group to which they belong rests to some extent upon the history and symptoms, but to a greater extent upon the interpretation of the *X*-ray.

The *observation group* are normal children who may or may not have calcifications in the parenchyma of the lung or hilum nodes. They may or may not be contacts; the tuberculin may be positive or negative. They are to be checked regularly.

The *suspicious group* show abnormal densities in the *X*-ray plate which suggest unhealed tuberculous areas, particularly at the hilum, but which are not characteristic enough to justify a definite diagnosis. Those in contact with open tuberculosis under unfavorable home conditions are considered suspicious notwithstanding freedom from symptoms and negative *X*-rays. These children are placed upon extra rest and a diet rich in vitamins and are treated in the open window rooms of the school. The nurse visits the home to help the parents with advice and guidance.

We apply the term *childhood type tuberculosis* to all active tuberculosis of the bronchial nodes unless associated with a destructive pulmonary lesion. Active tuberculosis, whether due to primary or secondary infection, requires sanatorium treatment or its equivalent until the behavior of the lesion is ascertained, for it is frequently difficult to ascertain whether the disease is due to primary or secondary infection. Some children will require bed rest for a prolonged period, others may be treated in a preventorium or open window room of a school, but most of them simply require readjustments in diet, rest, and play, and a cooperation between the home and school to conform to their needs.

Adolescence is a critical period for infected children, for then pulmonary tuberculosis begins to make its appearance. Children who were contacts or suspects have been followed in our clinics with periodic *X*-rays since 1920, and in many instances we have been able to follow the evolution from childhood type tuberculosis into adult pulmonary tuberculosis. It has been our experience that this occurs rarely with children who have undergone treatment in open window rooms or in the sanatorium and who have been in close contact with the clinics. On the other hand, those who refuse to cooperate quite commonly develop acute tuberculosis of the adult type during adolescence. Frequent re-examination of this group is the only way of diagnosing incipient pulmonary tuberculosis.

The trend of our program to control tuberculosis has been indicated throughout this paper. Not all of it has been realized; some of it may never be started, but failure to accomplish any of its features will not be due to a lack of interest or support from our people. The whole community is "tuberculosis conscious" and will support any reasonable measure which is proposed. The support of the local newspapers in our work has been sincere and most valuable.

Under the wise and able leadership of Dr. E. C. Shaw, Chairman of the Sanatorium Board of Trustees, each step of the program is carefully weighed, gradually developed, and it goes no further than is commensurate with the resources of the community. In this manner the full confidence of our citizens has been gained and they have given the tuberculosis work their united support.

DISCUSSION

V. C. ROWLAND, M.D., Cleveland: Dr. Hyde's paper shows a broad grasp of the problem of tuberculosis and of the importance of unified county-wide control. He is the type of man to head the county organization for the prevention and treatment of tuberculosis. When the head of a sanatorium acts as the head of the county tuberculosis work I think it is desirable also that he be designated as the head of the official tuberculosis service. The health commissioner has the legal responsibility and authority for the whole population of the county. Conversely the chief of tuberculosis in the health office should have an official connection with the sanatorium or tuberculosis hospital so that cooperation is assured and admissions and discharges controlled for the benefit of all in the community.

Other groups should be similarly correlated, if necessary through a tuberculosis commission. In this way the school health services, both public and parochial, child health associations, industrial groups, etc., may be represented.

The most important thing to be done from the broad public health viewpoint is to find the tuberculosis cases at the earliest possible moment so that effective treatment may be carried out. The majority of the cases are still brought under treatment quite late and their prolonged care is enormously expensive. Tuberculin testing of the school population aids in picking up the unknown carriers of the disease. Of 1200 first grade school children tested in Cleveland in 1932, only 8 per cent showed positive reactions. The reactors and

contacts may then be *X*-rayed at a central diagnostic clinic for that purpose.

It is difficult to get the consent of parents for routine tuberculin testing in the schools. The private practitioners could be educated to do more of it especially if standardized freshly diluted tuberculin were supplied to them through the health office on request.

As Dr. Hyde indicates it is important to develop a more efficient form of home treatment of tuberculosis. Here the cooperation of the family doctor is indispensable. In this connection also the private practitioner has an opportunity in the early recognition of cases. This can be done in connection with periodic health examinations. It is desirable to keep this work in the hands of the private physician but if the work is persistently neglected there can be no sound objection to the carrying out of these necessary preventive procedures by official or institutional authorities. The winning anti-tuberculosis campaign must be maintained. I believe it will be done best by developing the most cordial and cooperative feeling between the private and public health agencies.

THE RELATIONSHIP OF THE AUTOPSY SURGEON AND THE EMBALMER—A Preliminary Report

HISTORICAL NOTES

IN ORDER to get a sane, sensible viewpoint it is necessary here, as in most biological subjects involving social relationships, to develop a historical background for our study and in this way, to maintain a judicial and rational reaction to the problems involved.

The examination of the dead dates back into the nearly forgotten days of the earliest civilization. Hand in hand with the development of this Art of Embalming, the ancient Egyptian also studied his dead in a limited way to learn of the sickness which killed.

Embalming with these early Egyptians was of three grades; the first reserved for men of position and means, which cost one talent and according to which the brain was removed by an opening through the nasal fossae and the intestines through an opening on the left side of the abdomen, after which both cavities were stuffed with spices and aromatics, then the body was washed and spread over with gum and wrapped in bandages of linen. The second grade was adopted by families of moderate means and the third was resorted to by the poor, consisting simply in washing the body and macerating in lye for 70 days. This sort of thing led naturally to autopsies of a kind. Pliny assures us that Kings of Egypt permitted the opening of corpses for the purpose of discovering the cause of disease. This business of autopsies and the subject of human anatomy reached a very high state of civilization under the Ptolemies.

In the progress of medical science, pathology has been of fundamental importance. Before diseased parts of the human body could be studied there had to be a knowledge of the normal structure of the same parts. That is, the development of pathology was strictly dependent upon anatomy. *This close relationship is just as true today,* in the development of the individual doctor of medicine, as it was in the history of our science.

For practical purposes, we can today dismiss what little knowledge of human anatomy the dark ages held as a totally inadequate foundation upon which to erect an adequate conception of disease processes.

Beginning with the period of the Renaissance there are a few names which must be mentioned to sketch the development of pathology, or a true conception of the disease processes in the human body:

Vesalius, (1514-1564), champion of anatomic dissection, boldly departed from the dogma of Galen, which had dominated throughout the dark ages, to carry out his classical studies in anatomy. In this way he laid the foundation of surgery which Ambrose Pare, his contemporary, appreciated and made use of to help elevate it from the level of the barber.

Things, however, moved slowly until the appearance of John Hunter in the 18th century, when, by his dissections, a new impetus was given to all branches of medicine. As a student of medical research, Hunter knew no limitations.

On the European Continent, at the end of the XVIII century, anatomy and through it, surgery, progressed as the result of the efforts of *Bichat* (1791-1802).

During this time, internal medicine was plodding along as a semi-mystic cult, aided at first by the bombastic *Paracelsus* but aroused completely by the immortal discovery of *Harvey* in the early XVII century. Two hundred years later saw it definitely established on physiological principles by that versatile genius and teacher, Johannes Muller. Even while *surgery* was being founded through anatomic discoveries and *internal medicine* established on physiological principles, a new

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Foot-Note—In June, 1932, The Ohio Embalmers' Association took lead in this matter and appointed a committee to work with a similar committee to be appointed by The Ohio Society of Clinical and Laboratory Diagnosis. These two committees have worked together in complete agreement and cooperation. They have prepared, after a joint meeting and considerable correspondence, a tentative statement about autopsies and the manner in which they should be conducted. This tentative statement has been published in the official organ of The Ohio Embalmers' Association, and we have had the benefit of constructive criticism of the members of that Association. A further elaboration is now being prepared.

The help of The Ohio State Medical Association was asked and the subject was referred to the Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical Association. The members of this committee are: V. C. Rowland, Chairman; C. W. Burhans; Jonathan Forman; Beatrice T. Hagen; R. R. Hendershott; A. J. Skeel, and C. I Stephen This preliminary report was written by Jonathan Forman, Columbus, Ohio.

science came into being. This afterward became known as *pathology*, a synonym more practical but less expressive than the older title *morbid anatomy*.

The first great work in this field, entitled "The Seats and Causes of Diseases Investigated by Anatomy", by *Morgagni*, was published in 1761, more than one hundred years after *Harvey* and his discovery of the circulation of the blood. This book was epoch marking and stands as the true beginning of pathology in science. In this same year, 1761, there was born a Scotchman, *Matthew Baille*, who published the first complete text book on pathology and included case histories along with the *autopsy records*.

The scene again shifted to France where *Bayle*, *Laennec* and others created a lasting medical atmosphere by combining clinical manifestations with autopsy observations. Again utilizng morbid anatomy as a basis, Bright, Addison and Hodgkin, markedly advanced the cause of medicine in England. This was followed by the creation of the Viennese School by *Rokitansky*, the pathologist, and *Skoda*, the clinician, whose combined influence created in Vienna one of the world's greatest medical centers and marked the climax of gross pathological study.

Both medicine and surgery now veered into this new field of pathology for advancement. Following the cell theory of *Schleiden* and *Schwann* and the discoveries of the first great *microscopical anatomist*, *Henle*, microscopical anatomy became the great field for exploration. All the tissues of the various diseases were now being restudied by aid of the microscope. This was ably accomplished by the incomparable *Rudolph Virchow*. He was the most conspicuous figure in the history of medicine in the second half of the XIX century, the most successful exponent of scientific methods of medical investigation and research, the founder of modern pathology, wherein both the gross and microscopical changes of disease were correlated with and made to explain the symptoms of which the patient had complained. This magnificent achievement by which medicine became a science was based entirely upon carefully conducted *autopsies*. With this work, the so-called "dead-house" pathology became and has remained the single most important means of medical education. It is the primary school of medicine, contributing the knowledge that furnishes the foundation for medical education. By autopsies, with the aid of the microscope, the practice of medicine has been lifted out of a tangled mass of superstition and cultism and has been put on the basis of exact science.

Before leaving the historical introduction it will be interesting to sketch the American side of this story just a little in detail.

The earliest autopsy record in the American colonies is the brief report of the examination of the body of a boy, in September, 1639. "This boy was ill-disposed and his master gave him unreasonable correction and used him ill in his diet. After the boy got a bruise on his head, so as there appeared a fracture in his skull, being dissected after his death." So a search through early colonial records has revealed some dozen post-mortem examinations. All made as the result of a legal complaint and done in the prosecution of justice.

During most of the XIX century, the custom of resurrecting corpses for anatomical purposes was a necessary adjunct to the study of anatomy. In this country it never seemed to have aroused the uproar which it provoked in England and Scotland. Sometimes public sentiment was aroused as at the Worthington Medical School here in Central Ohio.

In the summer of 1840, a woman, from Marietta, died in the Ohio State Insane Asylum. Her people came to claim her body, but arrived too late because of the bad condition of the roads. It had been buried in the Potter's Field, in the old graveyard near High and Vine Streets. When the family arrived they found the grave empty. Two other graves had also been disturbed and suspicion pointed to the Worthington Medical College.

Shortly after this a rumor reached Worthington that a body of armed men was on its way from Delaware to search the college for the bodies that were missing. The president, Dr. Morrow, the faculty, the students and the friends of the college armed themselves with pistols, shot-guns and fortified themselves in the building.

The mob arrived. A Delaware lawyer made an inflammatory speech and the infuriated rabble rushed into the president's office and into his residence and searched them. They found nothing there but in an old corn shock back of the college building they did find the body of a negro. This maddened them still more. Battering rams were secured and it was decided to batter down the building. A pitched battle was about to begin when some one gave the key into the hands of the mob. Dr. Morrow seeing resistance useless offered to surrender and close the college if the faculty be allowed to take all the movable college property. This request was granted and the medical college in Worthington came to an end in 1840. It was re-established in Cincinnati and existed for many years as the Eclectic Medical Institute.

Out of this practice there came a dread of dissection and consequently a prejudice against autopsies which still exists to a great degree among our people. This accounts, in part, for the figures presented by the New York Academy of Medicine which shows the ratio of autopsies in the hospitals of Europe to those of the hospitals in America as 63 per cent to 7 per cent, about 9 to 1, while Karsner, the well-known pathologist of Cleveland, places the number for this country as a whole at 0.7 per cent. What are the other reasons for the difference? There are two outstanding reasons:

First—Lack of interest on the part of physicians. The cause of this has been analyzed as follows:

(1) Some physicians do not feel the need of a repetition of the pathologic observations upon which they base their diagnoses. For this class it is well to point out the figures of Karsner which showed that in a high class hospital, one of our best, there were 8 per cent gross errors with 60 per cent minor errors.

Frances Carter Wood summarized this situation in saying only the pathologist realizes how many patients with hysteria have brain tumors; in how many cases of heart disease there were not valvular lesions in the heart *but* there was a nephritis and finally, that 10 per cent of all old people die

of unsuspected cancer. We cannot be too careful nor can we be too diligent in checking our clincal experience with post-mortem examinations. This is the only way that medicine has developed and by having post-mortem examinations is the only way for a physician to improve himself and his skill. There is no other way, for in medicine the art is long and there are no short cuts.

(2) Another type of physician fears exposure of his ignorance. Fortunately, he is very rare indeed. We can dismiss him by saying that he is a good doctor to avoid and to add the comment that a few post-mortem examinations in the earlier days of practice would certainly have prepared him better.

(3) In the third group are those who are too busy to be troubled with post-mortem examinations. These, too, are not numerous. For their benefit, it has been pointed out that William Osler, the greatest physician America ever produced, learned his medicine in the dead house and always cancelled all appointments to attend necropsies on his patients. Such comment, however, is wasted for this is the type who either treats his patients in droves or else is a personal servant of the rich.

(4) Finally, the fourth group are disinterested or indifferent. Here the blame rests upon the pathologists. The post-mortem service can be sufficiently attractive to interest any physician interested in improving his professional knowledge. The pathologist should gauge his success, not by the variety of material appearing before him but by an increasing interest manifest in attendance and number of necropsies.

Second—Next to this lack of interest on the part of physicians, is the lack of appreciation on the part of the public. A difference of opinion exists regarding the cause of popular objection to post-mortem examinations. I have attempted to show where it came from historically. Wilson, of the Mayo Clinic, has called it a lack of selfish interest on the part of relatives to know the condition of the deceased as well as the light such an examination might throw on the whole family. The reports of the New York Academy of Medicine lay it at the door of ignorance of the value which this procedure has for science and, therefore, for the human race. Consequent upon this, there is a universal lack of appreciation on the part of the American public.

This may be resolved into its elementary factors most important of which is the "emotional." At the time of death, the high state of emotionalism in the family is not given consideration by the physician or by the pathologist, to whom an autopsy is only a perfunctory task. This familial sentimentality is always present and must be considered and encountered in a sympathetic manner and tactful manner.

To the emotion of love, there is to be added a certain amount of fear which has been attributed by many to religion. There still lingers in the subconscious mind of many, the medieval superstitions about the dead.

So far as religion is concerned, it seems that per se, it has been over-emphasized. This attitude of fear has no true foundation in any religious code and nowhere can such reference be found. We are all familiar with the pleading of Father Moulinier, the famous Jesuit Hospital administrator, for more autopsies. Careful investigation reveals that Jewish fear is more logically assigned to familial ties than to religion, although their ritual for preparing the body for burial does serve to arouse the familial sentimentality.

Aside from the apathy on the part of the physician and the ignorance and sentimentality of the public, in some communities there is a *third* factor in the attitude of the embalmer.

It has been our experience that the embalmer is always willing to meet the pathologist half way, but the physician performing the autopsy must be reliable and trustworthy. This is just another place to apply the golden rule.

The pathologist must be careful to leave the vascular tree intact and suitable for embalming and refrain from making an incision on the body that will show after it is dressed for burial. Wherever the pathologist has obeyed these rules, he has gotten the full and complete cooperation of the embalmer. In the twenty-one years that we have been performing autopsies in Central Ohio, our only troubles have been with poorly trained embalmers and those prejudiced by careless dissections who had not yet learned of our strict observance of these rules.

The Ohio Embalmers' Association showed the quality of its leadership by recognizing that it could do a lot for public good by starting a campaign of education for the pathologists, coroners and other physicians who, at times, do autopsies. Besides keeping the vascular tree intact and not mutilating the exterior of the body by inexperienced men, there are other annoyances which a little educational work would obviate, such as undue waiting for bodies, unkind treatment by attendants, thoughtless exposure of the body and levity in the morgue, especially in the presence of relatives of the deceased and delay in signing the death certificate. It is a debt we owe to the public, if medicine is to progress and physicians to know their work, to teach all concerned how to cooperate so that there may be more autopsies in every community.

At the January meeting, The Ohio Society of Clinical and Laboratory Diagnosis have made their committee a permanent one with Dr. Jonathan Forman as its chairman. A Bureau of Complaints has been established with Dr. Forman as Director.

This Bureau acts as a clearing house for all complaints from the embalmers against the carelessness of autopsy surgeons. In no instance will the name of the complainant be divulged, but the

attention of the offender will be called to his shortcomings. He will be given a copy of the suggestions as how to conduct an autopsy so as to help rather than to hinder the embalmer.

The Committee on Preventive Medicine, of the Ohio State Medical Association, has expressed the feeling that The Ohio Embalmers' Association deserves great credit in being the first organization to attempt to find a solution to this problem and The Ohio Society of Clinical and Laboratory Diagnosis for their work in helping carry through the program of mutual education. It is recommended that The Ohio State Medical Association lend its good offices to this movement.

SUMMARY

Modern medicine rests upon the dissection of the dead. Our knowledge of disease is dependent upon experiences gained from autopsies. Just as the science of medicine is dependent upon pathology, so, too, is the skill and the clinical judgment of the individual physician dependent upon his personal experiences as checked by post-mortem study of his patients when they die. The securing of more autopsies is, therefore, essential to medical progress. The movement for personal preventive medicine especially demand these. If an increasing number of autopsies are to be had, physicians and embalmers must cooperate to the end that the public come to appreciate the importance of autopsies.

—O S M J—

Cleveland Medical Library Association Holds Annual Meeting

At the annual meeting of the Cleveland Medical Library Association on January 19, the presidential address was delivered by Dr. Russell H. Birge, his subject being "Dr. Dudley P. Allen, Master-Surgeon". The talk was of especial interest to members of the Library Association because of Dr. Allen's services to it as a founder.

Dr. Clyde L. Cummer, Chairman of the Board, reported on Library activities during 1933. His report showed a total registration at the Library of 11,654; that the Library now comprises 47,029 bound volumes of books and journals, and that it is subscribing to 411 periodicals.

According to the report of Dr. C. W. Stone, the Director of Finance, and Dr. F. S. Gibson, the Treasurer, the income of the Association during the year was $24,524.08 and the expenditures $22,708.47 of which $15,384.69 was spent for library salaries, books, journals, and binding, and $6,650.71 for maintenance. The book value of invested funds amounted to $336,802.87.

Violin selections were given by Dr. Jerome Gross, accompanied by Mr. Leon Machan. Dr. Paul G. Moore gave an address, illustrated by lantern slides, on "Blindness in Certain Historic Characters".

The following officers were elected for the ensuing year: Dr. Russell H. Birge, President; Dr. Clyde L. Cummer, Chairman of the Board; Dr. C. W. Stone, Director of Finance; Dr. C. H. Lenhart, Director of the Library; Dr. A. A. Jenkins, Director of Maintenance; Dr. Howard Dittrick, Director of Program and Extension; Dr. Theodore Miller, Director of Membership; Dr. Thomas P. Shupe, Secretary; Dr. Frank S. Gibson, Treasurer.

Refreshments were served in the Cushing Reading Room after the meeting with Mrs. R. H. Birge and Mrs. F. F. Prentiss acting as hostesses.

—O S M J—

New Books Received

Treatment of the Commoner Diseases Met With by the General Practitioner, by Lewellys F. Barker, M.D., professor emeritus of medicine, Johns Hopkins University; J. B. Lippincott Company, East Washington Square, Philadelphia.

—O S M J—

The 1934 meeting of the Northern Tri-State Medical Association will be held at Flint, Michigan, on April 10.

IMPORTANT NOTICE TO THOSE WHOSE DUES ARE UNPAID

IN COMPLIANCE with Federal postal regulations, the names of all unpaid members of the State Association must be removed from *The Journal* mailing list after this issue.

If you are among those on the "delinquent" membership list of the State Association, your membership dues for 1934 should be transmitted to the Secretary-Treasurer of your medical society or academy of medicine immediately.

Prompt payment of dues will insure the continuance of *The Journal*, as well as other organization benefits. It is of vital importance, especially during these times of rapid and radical social, economic and governmental changes and developments, many of which have a direct and important bearing on the practice of medicine, that every eligible physician remain an active member of medical organization.

Membership dues for 1934 were due on or before January 1. As a courtesy to those who through neglect or oversight have thus far failed to pay their 1934 dues, *The Journal* has been mailed to them for the first three months of this calendar year. Only those whose dues are paid will receive future issues of *The Journal*, or be retained on the membership records.

CHANGES IN WORKMEN'S COMPENSATION SET-UP EXPECTED TO RESULT FROM INVESTIGATIONS NOW AUTHORIZED AND UNDER WAY

Extensive revision of the Ohio Workmen's Compensation Law and changes in the administrative procedure in connection with workmen's compensation cases are expected as a result of recent events and developments which have indicated the necessity for action to safeguard the compensation fund from abuse and fraud, and for the correction of weaknesses in the machinery set-up to administer the fund.

Investigation of the whole workmen's compensation system is scheduled to be started in the near future by a special committee appointed by Governor George White. Those who have accepted appointments on the special investigating commission are: O. B. Chapman, Dayton, acting president of the Ohio Federation of Labor; Thomas J. Donnelly, Columbus, secretary of the Ohio Federaton of Labor; Charles F. Michael, Bucyrus, president of the Ohio Manufacturers' Association, and Warren F. Perry, Columbus, secretary of the Ohio Manufacturers' Association. Former Governor James M. Cox, Dayton, had been asked to serve as chairman of the commission, but declined the appointment because of the press of private business affairs and his interest in other public matters. Subsequently, the Governor appointed S. P. Bush, Columbus industrialist, who took a prominent part in framing and establishing the present Ohio Workmen's Compensation plan, as chairman and the fifth member of the special commission.

In appointing this special committee, Governor White requested that it make a close study of the administration of the workmen's compensation plan and formulate recommendations for legislative and administrative adjustments.

For the past three years, the State Industrial Commission has been confronted with acute financial problems, the natural results of the prolonged business depression, unemployment, reduction of premium income, depreciation in the value of securities, constituting the reserve fund, and other economic factors.

However, it was not until several months ago that a climax in the situation confronting the Commission was reached and the necessity arose for prompt and vigorous steps to preserve the fund.

IRREGULARITIES DISCOVERED

Developments which led directly to the thorough investigation which has been authorized by the Governor followed the uncovering of serious irregularities in connection with the reporting of payrolls on the part of certain employers, notably a group of employer contractors in Cleveland.

At the time these irregularities, said to have defrauded the compensation fund of approximately $1,000,000 in unpaid premiums, were reported, the Governor instigated an investigation through the Department of Industrial Relations, looking to the collection of delinquent premiums and the prosecution of those connected with such irregularities.

The investigation made at that time by the Department of Industrial Relations revealed evidence of payroll irregularities on the part of additional employers aside from those under immediate investigation; evidence of collusion on the part of several employes of the Department; evidence of the filing of false and fraudulent claims by certain claimants; of collusion and the padding of fee bills by some physicians, and weaknesses in the compensation law and administrative system.

As a result of the departmental investigation which is still in progress, there has been collected a total of approximately $86,000 in premiums from three firms who had misrepresented their payroll expenditures upon which premium is based; findings have been made of premium due to the fund in the amount of approximately $300,000 on four other companies; data preparatory to prosecution and civil action is being assembled on 50 or more companies; and criminal action has been instituted against several persons involved in payroll irregularities.

Impetus was given to the State Administration's plan to take prompt steps to correct weaknesses in the compensation system, through legislation or executive order, by the widespread publicity given to a letter written to Governor White by Former Governor Cox under date of January 24, 1934, in which Mr. Cox cited abuses to which the fund has been subjected; called attention to certain weaknesses in the administrative machinery; and suggested that Governor White appoint a commission composed of representatives of capital and labor to make a complete investigation of the workmen's compensation system.

STRUCTURAL CHANGES ADVOCATED

Among Mr. Cox's suggestions as to the activities of the special commission which Governor White subsequently appointed, naming Mr. Cox as chairman, were: That the commission report on violations of the law; cite the need of changes in the law; recommend changes in the administrative procedure, and ascertain whether the Legislature is appropriating funds sufficient for proper personnel in the workmen's compensation division.

In reply to Mr. Cox's letter, Governor White commented as follows on one of the principal suggestions made by the former governor:

"I fully share your belief that weaknesses in the structure of the Ohio Workmen's Compensa-

tion Plan began to have their birth concurrent with the action which took place in 1921 when the Industrial Commission was divested of its power and control over the employes of the Ohio Workmen's Compensation Plan, which employes were placed under the Director of Industrial Relations in connection with the 'ripper' reorganization bill of 1921, thereby creating an unfortunate and unbusinesslike duality of relationship as between the Industrial Commission and the Department of Industrial Relations".

Amplifying his personal views on this matter, Governor White quoted from a communication received by him from Thomas A. Edmondson, State Director of Industrial Relations, in which Mr. Edmondson said:

"I have reached the conclusion, and it is my recommendation, that the Division of Workmen's Compensation should be removed from the Department of Industrial Relations, and the personnel of same be placed under the jurisdiction of the Industrial Commission of Ohio. I feel that it is very unfair to hold the Industrial Commission responsible for the payment of claims, the actuarial rating, and the premiums paid into the fund, and have no control over the personnel or its duties."

Mr. Edmondson stated to the Governor that the Director of Industrial Relations is in administrative charge of six other divisions and has been unable to give them the attention they should have because of his duties in connection with workmen's compensation administrative details, which condition would be eliminated by making the Division of Workmen's Compensation directly under the control of the Industrial Commission.

PROBLEMS OF ADMINISTRATION

In analyzing some of the problems confronting the Division of Workmen's Compensation, Mr. Edmondson said:

"The Division of Workmen's Compensation is greatly undermanned both as to the number of employes and to their ability to cope with conditions as they exist today. Especially is this true of the field section and the medical section.

"We have, at the present time, fifty-three men working in the field section. These men are required to investigate approximately nine thousand claims each year in addition to making the audits for every employer in the State of Ohio. It is a physical impossibility for these men to keep the work up to date as we have approximately forty thousand subscribers to the State Insurance Fund which means eighty thousand audits a year. In addition to the thousands of claims assigned for investigation there are also several thousand delinquent reports to secure each year, several hundred new applications, several thousand premium collections and several hundred rating inspection reports.

"There is urgent and immediate need in the medical section of additional examiners and office help. During the calendar year ending December 31, 1933, we made 4619 physical examinations here, and 9534 elsewhere in the state, a total of 14,153. Most of the local examinations are made by one physician, but during rush periods, others, on regular detail work, assist. Three medical examiners travel most of the time. There has been no increase in the road force for at least seven years although the work has steadily increased from year to year. We will manage to see the claimants, but cannot see them so frequently, and very often, it is physically impossible to examine them on time. This has resulted in lapse of compensation and criticism of the Division. Under present conditions, we cannot allow enough time for each claimant. Our examiners are hurried too much. This also applies to the office force. The same condition as to the personnel exists both in the auditing, actuarial and claims sections. The legal section is at present undermanned and in dire need of additional referees, reviewers, stenographers and special referees to act as deputies or assistants to the Commission."

PROCEDURE EXPECTED

Present indications are that the first step which will be taken to change the present set-up in administration of the compensation law will be that pertaining to transfer of the Division of Workmen's Compensation from the Department of Industrial Relations to the jurisdiction and control of the Industrial Commission.

This may be done by legislative amendment. Or, it may be done by executive order by the Governor transferring the employes now under the Director of Industrial Relations in the Division of Workmen's Compensation, to the jurisdiction of the State Industrial Commission. Governor White has requested the special investigating commission to consider this question immediately and has indicated a willingness to support the recommendation of the special commission as to the better method to accomplish such a transfer.

In addition to the investigation to be conducted by the special commission appointed by Governor White, a study of the operation and administration of the Workmen's Compensation Law is being undertaken by a special committee of the Ohio Senate, provided for in a resolutoin adopted last June 29 at the regular session of the 90th General Assembly. (See page 526, August, 1933, issue of *The Journal*.) The Senate committee, which is authorized to report its findings and recommendations relative to what, if any, changes should be made in the present Workmen's Compensation Law at any adjourned session of the 90th General Assembly or the regular session of the 91st General Assembly, which convenes in 1935, has held several meetings and is planning to call before it representatives of groups interested in workmen's compensation matters in order to obtain constructive suggestions pertaining to modification of the compensation statutes.

In this connection, it will be remembered that

in May, 1933, the Council of the Ohio State Medical Association, on recommendation of a Special Workmen's Compensation Committee appointed to confer with the Industrial Commission relative to serious financial problems confronting the Commission, adopted certain recommendations relative to the elimination of abuses on the part of some physicians, hospitals, nurses, and claimants, and looking toward improvement in the administrative procedure.

The recommendations of the Council (June, 1933, issue of *The Journal*, 377-380), which were conveyed to the Industrial Commission suggested among other things that more authority be vested in the local regional offices of the Commission; the Commission and the Medical Division stringently enforce the Rules and Regulations governing medical and hospital services which went into effect September 15, 1932; that regional medical boards of review be set up to review and pass upon chronic, prolonged, unusual and revived cases; that in flagrant cases of abuse and fraud prompt prosecution be instigated by the Commission under the fraud sections of the Workmen's Compensation Law; that a plan be devised whereby medical organization can furnish confidential information to the Medical Division on cases of suspected malingering, questionable cases and on the character and professional standing of physicans suspected of promoting abuses; that the medical and surgical fee schedule adopted in 1920 *not* be reduced, and that concerted effort be made to secure from the Legislature adequate appropriations for maintaining more efficient and effective administrative machinery.

The communication from the Council to the Commission pledged the support and cooperation of medical organization in constructive efforts to meet the problems of the Commission, safeguard the compensation fund from abuses, and bring about greater efficiency in administration of the law. Moreover, it pointed out that the elimination of obvious abuses, drastic action against repeated offenders and improvement in administration constituted the crux of the solution of the Commission's problems which could not be accomplished merely by reducing the fees for medical services, thus penalizing the honest physician and discriminating in favor of the dishonest members of the profession. However, the Commission inaugurated a temporary 20 per cent reduction of medical and surgical fees in workmen's compensation cases, believing a necessary and immediate decrease in expenditures was imperative. The recommendations of the Council for improvement in administrative procedure were pronounced meritorious by the Commission and accepted for future consideration by it.

COOPERATION BY EMPLOYERS

About the same time, the Workmen's Compensation Committee of the Ohio Manufacturers' Association held a number of conferences with the Industrial Commission and in a formal communication to the Commission recommended certain statutory and administrative changes that, it was felt, would help solve some of the Commission's problems, among which were the following: That the appeal statutes in regard to workmen's compensation cases be modified to eliminate the unnecessary and improper burdens upon the state insurance fund; that steps be taken to enforce all employers to pay premiums due the fund; that drastic action be taken against those dealing dishonestly in connection with compensation cases; and that weaknesses and delays in the handling of claims, fee bills, etc., at the Commission be corrected. The manufacturers' committee also recommended that no reduction be made in medical fees as "a horizontal cut in medical fees might be a temporary palliative but might accomplish no lasting good and probably would increase the present evils".

Over a period of years, the State Association has cooperated with other groups constructively concerned with the principle of workmen's compensation and with administrative procedure. Medical organization always has assisted in efforts to improve the administration of the law and has insisted that abuses, including those chargeable in any way to members of the medical profession, be eliminated. As indicated by the last official actions of the Council (June, 1933, *Journal*) and the House of Delegates (October, 1933, *Journal*, page 643), medical organization is anxious and willing to cooperate with and assist in solving the problems of the Industrial Commission; aid in eliminating abuses in order that the insurance fund may not be dissipated, and work with administrative officials in correcting flaws in administrative details.

—O S M J—

—The following officers have been elected by the staff of St. Elizabeth's Hospital, Youngstown: President, Dr. C. D. Hauser; vice president, Dr. H. M. Osborne; secretary-treasurer, Dr. Saul Tamarkin; members of the executive committee, Dr. J. E. Hardman and Dr. E. W. Coe, chief of surgical staff, Dr. F. W. McNamara, and chief of medical staff, Dr. E. W. Coe. At a recent program given by the staff on diseases of the heart, the following members spoke: Drs. I. C. Smith, N. W. Neidus, H. E. Chalker, M. J. Crow, and J. G. Brody.

—O S M J—

Lima—Thirteen physicans of Lima and surrounding cities have returned from a study at the clinics at Johns Hopkins University. They are: Drs. J. R. Tillotson, E. J. Curtiss, Harry Noble, W. A. Noble, C. H. Leech, George Wilkie, Fred Maurer, L. T. Brunk, J. W. Halfhill, E. H. Hedges, C. C. Berlin, H. L. Stelzer and Harvey Basinger.

—O S M J—

Cleveland—Dr. S. C. Lind has returned from post-graduate work at the clinic of Dr. F. de Quervain, Bern, Switzerland.

THE OHIO SUPREME COURT ISSUES DECISION AFFECTING PUBLIC HEALTH, VACCINATION AND WORKMEN'S COMPENSATION

A decision which may have an important bearing on the voluntary cooperation of employers of labor with public health authorities in promoting vaccination and other public health safeguards among their employes and on future interpretations of the meaning and scope of the term "injury" as used in the Ohio Workmen's Compensation Law was handed down recently by the Ohio Supreme Court in the case of The Spicer Manufacturing Company vs. Nellie Tucker.

In the hearing before the Supreme Court on an error proceeding appealing from a decision of the Court of Appeals of Lucas County which sustained a verdict and judgment in favor of Nellie Tucker in the Common Pleas Court, the following history of the case was recorded:

On February 26, 1930, William Tucker obtained employment at the plant of the Spicer Manufacturing Company, Toledo. While at work eight days later, he was ordered by the foreman to go to the first-aid hospital operated by the company and located on the company's premises. He did so and was there vaccinated by the company physician. It was brought out that the health commissioner of the city of Toledo had recommended to the company that all its unvaccinated employes be vaccinated to preclude the recurrence of a smallpox epidemic and that the company was acting upon this recommendation in having Tucker vaccinated.

After being vaccinated, Tucker resumed his work. His left arm gradually became inflamed, swollen and painful, and at the end of five days he was unable to continue his employment. He died on March 29, 1930. His widow, Nellie Tucker, filed a claim with the State Industrial Commission. This claim was denied by the Commission which stated that "it did not appear that the condition complained of was due to the decedent's employment, but resulted from a condition over which the employer had no control".

Subsequently, an application for rehearing was filed and the claim was again disallowed on the ground that "the decedent's death was not due to an injury received in the course of employment". An appeal from this action was filed in the Common Pleas Court of Lucas County by Nellie Tucker against the Spicer Manufacturing Company, a self-insurer under the Workmen's Compensation Law. The trial resulted in a verdict and judgment in favor of Mrs. Tucker, which was affirmed by the Court of Appeals.

CRUX OF DECISION

In arriving at its decision that "*an employe suffers an accidental injury arising out of and in the course of his employment when, during working hours, the employer, upon his own authority and for his own benefit, requires the employe to be vaccinated by the employer's physician, and the wound becomes infected, thereby causing death or disability*", the Ohio Supreme Court raised and considered the following three phases of the question of law presented:

(1) Did Tucker receive a physical "injury"?

(2) If so, was it "accidental"?

(3) Did it "arise out of or in the course of employment"?

Relative to the first of these three decisive questions, the Court said:

"The first of these presents little difficulty when it is remembered that the process of vaccination necessitated a scarifying and laceration of the skin and flesh with its attendant bleeding and pain. Beyond cavil this was a physical injury to the tissues of the arm; and this is so despite the expectation that the ultimate result of the process would be a distinct benefit greatly outweighing the apparent temporary minor disadvantages of the original trauma".

Having arrived at the conclusion that Tucker did receive an "injury" during the process of vaccination, the Court proceeded to consider the second phase of the question:

"The second phase of the matter is more difficult. Did Tucker experience an accident?

"It is agreed by counsel that Tucker's death resulted directly from the vaccination; but the plaintiff in error (Spicer Manufacturing Company) contends that the vaccination was not an accident. It must be conceded that there is no element of accident in an ordinary vaccination; but according to the evidence this was clearly not that sort.

"On page 56 of the printed record, Dr..... was asked: 'Was the infection in this wound unusual to vaccination?' The answer was: 'Yes, I think anyone who would see Mr. Tucker in his condition would have said so.' Again on the same page, Dr..... said: 'I have seen hundreds of cases of paralysis coming on and I never saw one come on like this.' Then on page 57, Dr..... was asked: 'Is this type of case a usual one, Doctor?' The answer was: 'No, it is very unusual.' On page 62, Dr..... said: 'In our office in the last fifteen years—this is an estimate, I think we have vaccinated about five thousand people and that is the first experience we have had of that type.'

"The plaintiff in error contends that Tucker's death resulted simply because he was one of those individuals whose system cannot withstand the introduction of vaccine. On the other hand,

the defendant in error insists that the death may have been caused either in this wise or by other infection entering the vaccination wound. However, the plaintiff in error maintains that there is no evidence to substantiate this latter theory.

"The fact is that the evidence does not definitely disclose which theory is correct. Neither of the two attending physicians was willing or able to do more than venture a cautious opinion. Possibly this is explained by the fact that Dr..... did not visit Tucker until nineteen days before death occurred, and Dr....., the company physician, who vaccinated Tucker, did not see him again until the day he died. But the result in this case must be the same under each theory. Irrespective of which thing happened, it was manifestly unforeseen, unusual, and unexpected, and therefore accidental. Can it logically be considered that the element of accident was any the less involved if the introduction of vaccine caused death for the first time in an experience of five thousand cases covering a period of fifteen years? Can it be said that the result was foreseen, usual, or expected?"

Concerning the third phase of the question—Did Tucker's injury arise out of or in the course of his employment?—, the Court declared:

"The plaintiff in error insists that vaccination was a known condition precedent to Tucker's employment. The chief difficulty with this contention is that there is no evidence to sustain it. The only such testimony offered by the company was that of the plant hospital supervisor, Stacey, who said a vaccination rule had been adopted; but he admitted that he did not employ Tucker and did not know whether Tucker had been informed of the rule. On the other hand, a witness by the name of Peacock testified that he and Tucker were together when they applied for employment, worked together, and were vaccinated together, but were told nothing about vaccination until the night their foreman ordered them to leave their work and go to the plant hospital. This was after they had been at work eight days.

"It is also urged by the plaintiff in error that Tucker was given the option of being vaccinated by the plant physician or by his own. Again, it is true that there is evidence showing the adoption of such a rule by the company, but there is none to the effect that Tucker was informed of such option. On the contrary, the witness Peacock testified that the foreman mentioned no option, and he recalled no such suggestion by the plant physician.

PUBLIC HEALTH PRINCIPLE

"Another contention of the plaintiff in error is that the purpose of the company's vaccination rule was to protect the citizens of the city of Toledo and preserve the public health. The defendant in error insists that the only purpose the company had in mind was its own advantage, by preventing interference with its plant operations. The probable truth is that both motives were present. The evidence shows that the health commissioner of the city had recommended such a rule to the company in order to preclude the recurrence of a smallpox epidemic, but it is agreed that the commissioner did not have authority to compel compliance with his recommendation.

"Furthermore, it is agreed that Tucker would have been discharged if he had not been vaccinated. In other words, it was impossible for him to continue his employment without complying with the company's order. The preemptory nature of the foreman's instruction is shown by the fact that the moment Tucker received his order he and his companion, Peacock, left their work and went to the plant hospital. Within fifteen or twenty minutes the process of vaccination was completed and they were back at their work. In this connection it is worthy of note that their absence from the work resulted in no deduction from their pay.

"Under this combination of circumstances can it be said that the injury did not arise out of or in the course of Tucker's employment; or can it be said that the injury had its cause outside of and disconnected with the employment? This court is unanimously of the opinion that both reason and authority manifestly require a contrary conclusion. In view of the foregoing, the judgment must be affirmed."

Legal authorities who have studied the decision of the Supreme Court in the Tucker case are of the opinion that it broadens considerably the scope of the term "injury" as used in the Ohio Workmen's Compensation Law and may have a liberal effect in the admission of claims for compensation under the compensation law.

Moreover, they point out that the decision undoubtedly will have a tendency to curtail to some extent the voluntary cooperation of industry with public health officials in public health matters since employers will be reluctant to take the responsibility of seeing that their employes are vaccinated, especially while at work and by physicians employed by the industry, and assuming the liability in cases which might terminate fatally or in permanent or partial disability.

—O S M J—

The Call Service of the Cleveland Academy of Medicine has a total enrollment of 366 members. During the year of 1933 nearly 11,000 patients of Academy members were served by the bureau. Two hundred and thirty-nine emergency calls were handled and nearly 2500 information calls were answered.

—O S M J—

—Dr. W. B. Lacock has been reappointed health commissioner of Logan and Hocking County.

ONE HUNDREDTH ANNIVERSARY CELEBRATION OF COLLEGE OF MEDICINE ATTRACTS WIDE INTEREST AND LARGE ATTENDANCE

Hundreds of graduates of the College of Medicine, Ohio State University, were assembling on the university campus, March 1, for the One Hundredth Anniversary Celebration of the College of Medicine, which opened Thursday, March 1, and lasts through Saturday, March 3.

The "Century of Progress in Medical Education" held by the college depicts the development, progress and growth of the oldest medical school west of the Allegheny Mountains; attracts one of the largest gatherings of alumni ever held at the University, and offers one of the best scientific programs to be presented during the year in the Middle West.

The Honorary Centennial Committee includes: Governor George White, Dr. George W. Rightmire, president of the University; Dr. William H. Scott, former president; Herbert S. Atkinson, Julius E. Stone, trustees; and Charles F. Kettering, J. L. Morrill, vice president of the University; Dr. Roy D. McClure, Detroit, former president of the Ohio State University Alumni Association; Dean William McPherson, head of the Graduate School; Dean Walter Shepard, College of Arts and Sciences; Dean Harry Seaman, College of Dentistry; Dean Clair A. Dye, College of Pharmacy; Bland L. Stradley, Entrance Examiner; Dr. James F. Baldwin, Dr. John W. Wright, Dr. Francis Carter Wood, Dr. Charles S. Hamilton, and Dr. Frank Warner.

The General Committee on Arrangements is composed of Dr. J. H. J. Upham, dean of the College of Medicine; Dr. V. A. Dodd, John B. Fullen, secretary of the alumni association; Dr. Charles A. Doan, H. K. Shellenger, director of the University News Bureau; Dr. Jonathan Forman and Dr. Ernest Scott, general chairman.

Dr. Russell G. Means is in charge of class reunions; Dr. Albert Landrum of fraternity banquets, and Dr. Charles A. Doan of awards of honor. Dr. George M. Curtis and Dr. V. A. Dodd have arranged the clinical program. The program depicting the history of the college has been arranged by Dr. Jonathan Forman, Dr. Harlow Lindley and Iowa D. Smith. The exhibit and medical and dental equipment used in Ohio during the past 100 years has been arranged by Dr. H. R. Goodwin, Dr. Dwight Palmer and Dr. Paul C. Kitchen.

The complete official program for the celebration follows:

Thursday, March 1

9-10 A.M.—Registration—Headquarters, Hamilton Hall.

9 A.M.—Clinics in Medicine and Surgery by the staffs of the University and St. Francis Hospitals.

2 P.M.—Demonstrations in Various Laboratories.

6:15 P.M.—Optional Dinner, Faculty Club.

8:15 P.M.—Dean J. H. J. Upham Presiding, The Chapel. The History of Medical Education, Dr. Francis Packard, Editor, *Annals of Medical History, Philadelphia, Pa.* The History of the College of Medicine, Dr. Jonathan Forman, Arts, '10, Editor, *Phi Rho Sigma*, Columbus, Ohio. The Place of Medical Education in the State University, Dr. George W. Rightmire, B.Ph., '95, M.A., '97, President, Ohio State University, Columbus, Ohio.

Friday, March 2

10:30 A.M.—Convocation, University Hall Chapel, President Rightmire, Presiding. Conferring of Honors on Alumni and others. The Challenge of the Future to Medical Education, Dr. Henry S. Houghton, Arts, '01, Associate Dean, Biological Sciences, Chicago University, Chicago, Illinois. Presentation of Honors.

12:30 P.M.—Luncheon to delegates and guests, Faculty Club. Class Reunions (apply Registration Desk for information).

2:00 P.M.—Addresses—Campbell Hall. Cancer, Dr. Francis C. Wood, B.Sc., '91, editor, *Journal of Cancer*, Crocker Foundation, New York, N. Y. Tularemia, Dr. Edward Francis, B.Sc., '94, United States Public Health Service, Washington, D. C. Metabolism in Medicine, Dr. William S. McCann, Arts, '11, Chairman, Department of Medicine, Director Strong Memorial Hosptal, Rochester, N. Y.

6:00 P.M.—Fraternity Banquets: Phi Rho Sigma, University Club; Phi Chi, at house, 354 W. Ninth Ave.; Alpha Kappa Kappa, Columbus Athletic Club; Alpha Mu Pi Omega; Theta Kappa Psi, at Fort Hayes Hotel; Phi Delta Epsilon, at house, 203 W. Tenth Ave.; Alpha Epsilon Iota, Cambridge Arms.

Saturday, March 3

Surgical Clinics: University Hospital.

8:00 A.M.—Dr. Gatewood, Arts, '07; M.A., 10, Associate Professor of Surgery, Rush Medical College, Chicago, Illinois.

9:00 A.M.—Dr. Mont Reid, Chairman, Department of Surgery, University of Cincinnati, Cincinnati, Ohio.

10:00 A.M.—Dr. Roy D. McClure, Arts, '04, Surgeon-in-Chief, Henry Ford Hospital, Detroit, Mich.

Medical Clinics: Campbell Hall.

9:00 A.M.—Dr. F. A. Hartman—Cortical Hormone, Professor Physiology, University of Buffalo, Buffalo, New York.

10:00 A.M.—Dr. Torald H. Sollman, Dean Col-

lege of Medicine, Western Reserve University, Cleveland, Ohio.

11:00 A.M.—Medical and Surgical Groups. Irradiation Therapy: Dr. George T. Pack, Arts, '20, Memorial Hospital, New York, N. Y.

12:30 P.M.—Buffet Luncheon for Alumni and Guests, University Hospital.

2:00-4:30 P.M.—Clinics at University Hospital: Dr. Robert Zollinger, Arts, '25; Med., '27, Surgical Clinic, Peter Brent Brigham Hospital, Boston, Massachusetts. Dr. R. A. Moore, Arts, '21; M.A., '27; Med., '28, Associate Professor Pathology, Cornell Medical Center, New York, N. Y. Dr. Raymond L. Pfeifer, Med., '28, Institute of Opthalmology, Columbia Medical Center, New York, N. Y. Dr. Samuel T. Mercer, Med., '29, Research Fellow, Department Dermatology, Columbia Medical Center, New York, N. Y.

6:00 P.M.—Alpha Omega Alpha Initiation and Supper, Faculty Club.

8:00 P.M.—Public Alpha Omega Alpha Address, Campbell Hall, Dr. Charles Emerson, Former Dean, Medical College, Indiana University, Bloomington, Indiana.

—O S M J—

Steps to Relieve Unemployment Among Registered Nurses

Further cooperation of the physicians of Ohio in the efforts of the Ohio State Nurses' Association to relieve unemployment and suffering among the nurses of the state is asked in a communication under date of February 8, signed by Marguerite E. Fagen, R. N., president of the Ohio State Nurses' Association, and sent to the secretaries of the county medical societies and academies of medicine of the state.

It is said that physicians have actively cooperated with the nurses' association in establishing an eight-hour day for members of the nursing profession throughout the state, which has aided in relieving the unemployment among nurses.

In her communication to the county society and academy secretaries soliciting additional support and cooperation in attempts to some of the economic problems of nurses, Miss Fagan said in part:

"The Board of Trustees of the Ohio Nurses' Association, in its endeavor to relieve the great unemployment and suffering among our Ohio nurses, is appealing to the members of your local academy of medicine to support us in our interpretation of certain ethical policies.

"Complaints have been received from many nurses relative to the tendency on the part of some physicians and hospitals to ask the graduate registered nurse to give free nursing service when the hospital has received full remuneration for all hospital expense, and, again when the hospital and the physician have received compensation for services rendered.

"Because of these numerous complaints our State Committee on Employment has recommended to the Board of Trustees of the O.S.N.A. (and the Board approved the recommendations) the following:

" 'That voluntary nurse service should be available only for the patient who is a free patient in the hospital ward or under the doctor's care at home. If the hospital or doctor receive full or partial remuneration then the nurse should not be expected to give free service.'

"We want to thank your local academy of medicine for the splendid support given us in establishing the eight-hour day for nurses on a statewide basis.

"We want to emphasize again that all our nurses, through alumnae and district associations and our official registries, are willing to give free nursing service whenever it is necessary. Our records show that nurses are giving free service in practically every hospital in Ohio, as well as in many homes. For more than a year many nurses have been working from four to six hours a day in hospitals in return for board, room and laundry.

"We feel sure we can count on the cooperation of your local academy of medicine in our effort to bring about a more ethical procedure in compensating nurses for their services and in establishing the eight-hour day for nurses to the exclusion of all other hours of service in hospitals, if not in the home."

As pointed out by Mrs. Elizabeth P. August, general secretary of the Ohio State Nurses' Association, in an article published in the January, 1934, issue of *The Journal* relating to the eight-hour day program, physicians are in a position to be of material assistance in efforts to relieve unemployment among nurses through their contacts with patients and hospitals and by cooperating with nurses' organizations in trying to solve unemployment, financial, and other questions of similar importance.

—O S M J—

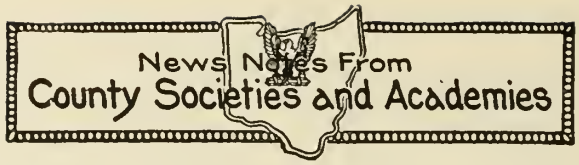
The second of a series of clinical lectures sponsored by the Commonwealth Fund and the staff of Detwiler Memorial Hospital, Wauseon, was held on January 25 at the hospital with Dr. A. Graeme Mitchell, professor of pediatrics, University of Cincinnati, as the guest speaker. Dr. Mitchell conducted clinics in the morning and in the afternoon addressed the fifty physicians present on "A Consideration of the Practical Aspects of Nutrition".

—O S M J—

Dr. Lewis S. Pilcher, New York City recently celebrated the golden anniversary of his editorship of *The Annals of Surgery.*

—O S M J—

Cleveland—Dr. Bradley M. Patten has resigned as associate professor of histology and embryology, Western Reserve University, School of Medicine, to become assistant director of medical sciences for the Rockefeller Foundation.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(Harold F. Downing, M.D., Secretary)

February 5—General session. Program: "Frontier Nursing in Kentucky", Mary Breckenridge, R. N., Wendover, Ky.

February 12—General session. Program: "The Present Status of Endocrinology—A Review", Dr. Louis A. Lurie; discussion by Dr. J. V. Greenebaum; "The Importance of Post-Partum Care," Dr. James M. Pierce; discussion by Dr. Henry L. Woodward and Dr. Frank M. Coppock, Jr.

February 19 — General session. Program: Symposium on "The Private Hospital in Community Life". "Group Hospitalization", Dr. Walter E. List; discussion by William Frersing; "Hospital Background", Rev. Carroll H. Lewis; "The Private Hospital", Rev. Father R. Marcellus Wagner; "Why A Children's Hospital", Francis Van Buren.

February 26 — General Session. Program: "Fads and Fancies in the Treatment of Acute Empyema", Dr. Evarts A. Graham, professor of surgery, Washington University School of Medicine, St. Louis.

Clinton County Medical Society met in regular session February 6 at Wilmington. The guest speaker was Dr. Robert L. Crudgington, Cincinnati, who gave an interesting talk on "Practical Obstetrics".—E. D. Peelle, M.D., Secretary

Second District

Clark County Medical Society held its annual banquet January 25 at the Springfield City Hospital. The guest speaker was Dr. E. A. Hamilton, Columbus, who discussed "Colitis".—News Clipping.

Darke County Medical Society had as its guest speaker on January 19, Dr. W. N. Taylor, Columbus, who spoke on "Problems in Urology". A dinner was served preceding the meeting at the Service Restaurant.—News Clipping.

The society was addressed on February 16 by Dr. Robert Austin, Dayton, on "Pitfalls in Abdominal Surgery". Two patients were presented at the clinical demonstration which followed.—Bulletin.

Greene County Medical Society met January 4 at Xenia with Dr. James Beavis, Dayton, as guest speaker. Dr. Beavis discussed "Cleft Lip and Palate". He presented slides on a remarkable collection of cases. Following the installation of officers, the society lunched at the Iron Lantern.

At its meeting on February 1, the society was addressed by Dr. C. D. Fife, Dayton, on "Influenza and its Complications". The literature was reviewed and the writer's personal experiences were presented. Some recent developments in treatment were brought out as used in the Miami Valley Hospital, Dayton.—H. E. Ray, M.D., secretary.

Miami County Medical Society met in regular session February 2 at the Stouder Memorial Hospital, Troy. A paper on "The Diagnosis, Chemical Significance and Treatment of Premature Systoles" was read by Dr. John T. Quirk, Piqua. The discussion was opened by Dr. G. E. McCullough, Troy. Dinner was served following the program.—Bulletin.

Montgomery County Medical Society was entertained on February 2 at St. Elizabeth's Hospital. Following a complimentary dinner, a program of papers and clinical demonstrations was presented by the members of the hospital staff.

On February 16, the society was entertained by a "Symposium on Arthritis and Rheumatism". The following phases of the subject were presented by the following speakers: "The Medical Aspects of Chronic Arthritis", Dr. T. E. Newell; discussant, Dr. H. D. Cassell; "Orthopedic Aspects", Dr. J. Hartman; discussant, Dr. H. L. Brumbaugh; "Rheumatism and Arthritis as Seen by a Pediatrician", Dr. S. H. Ashmun; discussant, Dr. C. C. Payne.—Bulletin.

Preble County Medical Society met on January 18 at Seven Mile Tavern, Eaton. Following dinner, Dr. Stanley E. Dorst, Cincinnati, addressed the society on "The Present Status of Vaccine Therapy".—News Clipping.

At its meeting on February 15, the society was addressed by Dr. G. C. Gilfillen, Dayton, on "Practice of Obstetrics".—Bulletin.

Third District

Auglaize County Medical Society was addressed on February 15 by Dr. E. H. Hedges, Lima. Dr. Hedges spoke on 'Treatment of Prostatic Hypertrophy".—News Clipping.

Hancock County Medical Society met in regular session, February 1, at the Elks' Club, Findlay. Dr. R. S. Rilling, Findlay, was the guest speaker, discussing "Club Feet".—H. O. Crosby, M.D., secretary.

Hardin County Medical Society met January 18 at the Kenton Cafe. Dr. R. O. Rush, Lima, was the guest speaker. He discussed "Skin Diseases".—New Clipping.

Logan County Medical Society was addressed

on February 2 by Dr. H. W. Koerper, Columbus, who discussed "Eclampsia".—R. A. Firmin, M.D., secretary.

Marion County—Seventy physicians and nurses, including guests from Carey, Marysville, Delaware and Cardington, attended the February 6 meeting of the Marion County Academy of Medicine. An interesting article, "Historical Note", written by Ignatz Semmelweis, was read by Dr. Maud L. Bull. An unusual and interesting case report of an illness of 17 years' duration was presented by Dr. J. G. McNamara. The guest speaker was Dr. William J. Dieckman, assistant professor of obstetrics, University of Chicago, and on the staff of the Chicago Lying-In Hospital. Dr. Dieckman, who spoke under the auspices of the Obsterics Section of the Academy, discussed, "Toxemias of Pregnancy, Especially the Non-Convulsive Type". Two original films showing complications of the second stage of labor and postpartum hemorrhage were shown and described by the speaker.—J. W. Jolley, M.D., secretary.

Seneca County Medical Society met in regular session January 18 at the Shawhan Hotel, Tiffin. A discussion on "Cancer" was presented by Dr. Robert W. Benner. A general round-table discussion followed the paper.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

February 2—Section on Pathology, Experimental Medicine and Bacteriology. Program: "Erosions of the Cervix During Pregnancy, Simulating Cervical Carcinoma", Dr. Theodore Zbinden; "Carcinoma of the Cervix, With a Review of 50 Cases", Dr. William H. Meffley; discussions opened by Dr. H. B. Meader and Dr. J. T. Murphy.

February 9—General Session. Program: "Malignant Diseases of the Upper Mucous Membrane Tract", Dr. Douglas Quick, New York City.

February 16 — Medical Section. Program: "Bright's Disease—Its Classification and Therapy", Dr. R. H. McDonald, Cleveland.

February 23 — Surgical Section. Program: "*X*-ray Treatment of Uterine Bleeding and Fibroid Tumors", Dr. J. T. Murphy; discussion opened by Dr. L. F. Smead and Dr. F. M. Douglas.

Defiance County Medical Society met January 16 at the Kettering Golf Club with a good attendance. The guest speaker was Dr. George Curtis, Columbus, who spoke on "Surgery of Tuberculosis". Refreshments were served following the program.—D. J. Slosser, M.D., secretary.

Ottawa County Medical Society has elected officers as follows for the ensuing year: President, Dr. R. A. Willett, Elmore; vice president, Dr. E. D. Schuiteman, Genoa; secretary-treasurer, Dr. Cyrus R. Wood, Port Clinton; legislative committeeman, Dr. H. J. Pool, Port Clinton; medical defense committeeman, Dr. F. E. Miller, Curtice; delegate, Dr. Poole; alternate, Dr. C. J. Yeisley, Port Clinton.—Cyrus R. Wood, M.D., secretary.

Paulding County Medical Society has elected officers for the ensuing year as follow: President, Dr. C. E. Houston, Paulding; vice president, Dr. Ray H. Mouser, Paulding; secretary-treasurer, Dr. G. L. Doster, Paulding; legislative committeeman, Dr. L. R. Fast, Paulding; delegate, Dr. Fast; alternate, Dr. Houston.

Wood County Medical Society in session January 18 at Bowling Green was addressed by Dr. W. W. Beck, Toledo, on "Some Observations on the 48-Hour Appendix". At the business session, problems of medical relief for the needy poor were discussed.—News Clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

February 2—Clinical and Pathological Section. Program: "Osteoma of Orbit and Frontal Sinus", Dr. W. B. Chamberlin; "Case of Annular Pancreas Producing Dilatation of Duodenum", Dr. J. H. Holloway; "Transplantation of Fibula to Arm for Flail Shoulder", Dr. Maxwell Harbin; "Section of Eighth Cranial Nerve for Meniere's Disease", Dr. C. S. Beck; "Hemiplegia in the Course of Malarial Therapy for Paresis", Dr. J. R. Driver; "Acute Case of Amoebic Dysentery", Dr. A. S. Dowling; "Unusual Case of Chronic Glomerular Nephritis", Dr. J. M. Hayman, Jr.; "Summary of 50 Cases of Inflammatory Rectal Stricture", Dr. Alan N. Moritz.

February 9—Joint meeting of Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program: "Comparison of the Pharmacologic Action of Atropine and Its Optical Isomers, Levo- and Dextro-Hyoscyamine", Dr. W. F. von Oettingen and I. H. Marshall, B.S.; "The Destruction of Levo-Dextro- and Racemic-Hyoscine by Egg White and Rabbit's Serum", Dr. Oettingen and Mr. Marshall; "Comparative Efficiency of Ergot Preparations on the Post-Partum Human Uterus", Dr. J. L. Jones and O. W. Barlow, Ph.D.; "Comparative Efficiency of Antidotes Against Avertin, Chloral and Pentobarbital", Mr. Barlow.

February 14—Practice of Medicine Section. Program: "The Ambulatory Cardiac—A Follow-Up Study of 100 Cases", Dr. L. G. Steuer and Dr. M. H. Fineberg; "Urea Clearance as a Test of Renal Function", Dr. R. H. McDonald; "The Relation of Kidney Function Tests to the Number of Glomeruli", Dr. J. H. Hayman.

February 16 — General Session. Program: "The Control of the Acute Infections of Children", Dr. W. H. Park, New York City.

February 20—Military Medicine Section. Pro-

gram: "What Is Expected of the Medical Department in Cleveland in the Next National Mobilization of Troops", Dr. Scott C. Runnels.

February 21—Industrial Medicine and Orthopedic Section. Program: "Presentation of Fracture Cases", Dr. W. H. Odell and Dr. J. M. Hamilton; "Presentation of Orthopedic Cases", Dr. C. G. Barber.

February 23—Ophthalmological and Oto-laryngological Section. Program: "Surgical Emphysema of the Neck Following Tonsillectomy Under General Anesthetic", Dr. E. W. Garrett; "Congenital Bilateral Dislocation of Lens", Dr. M. Paul Motto; "Endothelioma of the Nasal Septum", Dr. F. W. Merica; "Amblyopia as a Complication of Amenorrhea", Dr. Benjamin Wolpaw; "Case Report", Dr. H. E. Mitchell; "Orbital Tumor", Dr. M. Gans; "Sarcoma of the Naso-Pharynx", Dr. Walter Rieger.

February 28—Pediatric Section. Program: "Brain Tumors in Infancy", Dr. Sidney W. Gross; "Brain Injuries in Childhood", Dr. Donald Bell.

Ashtabula County Medical Society met on January 9 at the Broadway Inn, Geneva. The guest speaker was Dr. J. C. Placek, Cleveland, who spoke on "The Early Diagnosis of Tuberculosis and Methods of Treatment". Four physicians were voted into membership, namely: Dr. Harry A. Tagett, Ashtabula; Dr. Harold O. Tagett, Rock Creek; Dr. J. H. Thompson, Ashtabula, and Dr. Harry K. Lynne, Jefferson.—A. M. Mills, M.D., secretary.

Lake County Medical Society met in regular session on January 30 at which time Dr. A. J. Skeel, Cleveland, addressed the society on "Findings of the New York Academy of Medicine With Respect to Maternal Mortality".—Mabel L. Pearce, M.D., secretary.

Lorain County Medical Society was addressed on February 13 by Dr. S. V. Burley on "Focal Infection". Dinner was served at the Congregational Church preceding the program.—Bulletin.

Medina County Medical Society met on January 18 at Evanon. Several obstetrical films were shown preceding the chicken dinner. Fifteen members were present.—J. K. Durling, M.D., secretary.

Trumbull County Medical Society was addressed by Dr. L. L. Bigelow and Dr. Andrews Rogers, both of Columbus, at its meeting on January 18 at Warren. Dr. Bigelow spoke on "Medical Milestones". Dr. Rogers discussed obstetrical problems.—R. H. McCaughtry, M.D., secretary.

Sixth District

Union Medical Association, comprising the county medical societies of the Sixth District, elected the following officers for the ensuing year at its meeting January 10 at Massillon: President, Dr. J. D. Holston, Massillon, and secretary, Dr. J. H. Seiler, Akron. Dr. Holston succeeds Dr. A. E. Brant, Youngstown. Dr. Seiler has been secretary of the organization for many years.

Ashland County Medical Society met in regular session January 12 at the Samaritan Hospital, Ashland. At the business session, medical problems in connection with poor relief work were discussed. Dr. E. L. Clem presented a paper on "Trans-urethral Resection of the Prostate Gland". Plans were made for entertaining the wives of the members at the next meeting.—M. J. Thomas, M.D., secretary.

Mahoning County Medical Society held its annual banquet on February 1 with about 300 physicians and dentists in attendance. The principal speaker was Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*. Dr. Fishbein spoke on "Some Present Day Changes in the Practice of Medicine". His address was a brilliant and comprehensive review of changes in medical practice during the past half century. He emphasized the fact that only the medical man is qualified to say how and in what manner the practice of medicine can best be carried on for the greatest service to humanity and admonished the profession to abide by the ethical principles laid down by the fathers of medicine. Dr. Fishbein said that changes in medical practice should come through evolution, not revolution, and that the physician should keep in mind that the welfare of the patient must always come first.

On February 20, the society was addressed by Dr. Irvin Abell, clinical professor of surgery, University of Louisville. At the March 20 meeting of the society, Dr. William E. Lower, and Dr. William J. Engel, both of Cleveland, will be the guest speakers.

Dr. J. B. Nelson, president of the society, has appointed the following committees for the ensuing year:

Editorial—Dr. Claude B. Norris, editor; Dr. Samuel Tamarkin, advertising manager; Dr. John Noll, assistant advertising manager; Dr. W. E. Whelan, Dr. C. H. Campbell, Dr. J. G. Brody, Dr. H. E. Patrick, Dr. Morris Deitchman, Dr. Sidney McCurdy, Dr. A. W. Thomas, Dr. Saul Tamarkin, Dr. J. B. Birch, Dr. J. P. Harvey.

Program—Dr. H. J. Beard, chairman; Dr. M. H. Bachman, Dr. W. H. Bennett, Dr. P. L. Boyle, Dr. J. D. Brown, Dr. E. W. Cliffe, Dr. M. P. Jones, Dr. J. E. L. Keyes, Dr. P. R. McConnell, Dr. F. F. Monroe, Dr. M. D. Neidus, Dr. J. M. Ranz, Dr. John Shaffer.

Central Office—Dr. R. B. Poling, chairman; Dr. A. E. Brant, Dr. W. H. Evans, Dr. F. F. Piercy, Dr. I. C. Smith.

Economics—Dr. W. K. Stewart, chairman; Dr. Sidney McCurdy, Dr. R. G. Mossman, Dr. E. J. Reilly, Dr. William M. Skipp.

Public Relations—Dr. Paul J. Fuzy, chairman; Dr. F. J. Bierkamp, Dr. P. H. Leimbach, Dr. J. L. Scarnecchia, Dr. William M. Skipp, Dr. A. W. Thomas.

Publicity—Dr. J. L. Fisher, chairman; Dr. Louis Deitchman, Dr. W. X. Taylor.

Membership—Dr. J. P. Harvey, chairman; Dr. S. W. Hartzell, Dr. J. E. Hardman, Dr. B. B. McElhaney, Dr. W. W. Ryall, Dr. P. B. H. Smith, Dr. Clarence Stefanski, Dr. A. C. Tidd, Dr. C. F. Yauman.

Housing and Library—Dr. E. E. Kirkwood, chairman; Dr. L. H. Getty, Dr. Andrew Miglets, Dr. W. E. Ranz.

Legislative—Dr. O. J. Walker, chairman; Dr. F. W. Mcamara, Dr. R. H. Middleton.

Public Health—Dr. H. E. McClenahan, chairman; Dr. J. U. Buchanan, Dr. L. G. Coe, Dr. C. D. Hauser, Dr. H. E. Hathhorn, Dr. W. E. Love, Dr. A. Rosapepe.

Auditing—Dr. H. L. Zeve, chairman; Dr. A. E. Frye, Dr. A. C. Montani.—Boyd W. Schaffner, M.D., Correspondent.

Portage County Medical Society was entertained

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on February 1 at the home of Dr. J. S. Deyell, Ravenna. The guest speaker was Dr. Perry McCullagh, Cleveland, who spoke on "Research in Endocrinology". Dr. George J. Waggoner, Ravenna, discussed "Legislation and the Doctor".—Bulletin.

Richland County Medical Society was addressed on January 25 by Dr. Walter A. Hoyt, Akron, on "Hip Joint Diseases". Dr. H. S. Davidson, Akron, councilor of the Sixth District, was present and discussed organization activities. The following officers were installed: President, Dr. P. A. Stoodt; vice president, Dr. B. E. Schreffler; secretary-treasurer, Dr. D. A. Weir; legislative committeemen, Dr. C. R. Keller, Dr. J. S. Hattery, and Dr. L. Adams; delegate, Dr. W. E. Wygant, alternate, Dr. E. Dowds.—D. A. Weir, M.D., Secretary.

Stark County Medical Society held its annual meeting January 9 at the Elks' Club Canton. The following officers were elected: President, Dr. L. A. Buchman, Canton; vice president, Dr. M. E. Scott, Massillon; secretary-treasurer, Dr. H. W. Beck, Canton; delegates, Dr. J. P. DeWitt and Dr. C. M. Peters; alternates, Dr. W. C. Manchester and Dr. L. B. Zintsmaster. The program was presented by Dr. M. E. Scott and Dr. D. D. Shontz, both of Massillon. Dr. Scott discussed "Ludwig's Angina—Diagnosis, Complications and Treatment". Dr. Shontz read a paper on "The Treatment of Auricular Fibrillation".—Bulletin.

Summit County Medical Society at its meeting January 9 at the Mayflower Hotel was entertained with a program arranged by the Committee on Medical Progress. Papers dealing with various phases of medical progress in 1933 were read by the following: "Pediatrics", Dr. R. S. Friedley; "Eye, Ear, Nose and Throat", Dr. R. F. Thaw; "Orthopedic and Traumatic Surgery", Dr. F. B. Roberts; "General Surgery", Dr. G. K. Parke; "Urology", Dr. G. E. Chittenden.

The speakers at the February 6 meeting of the society were Dr. C. E. Jelm and Dr. G. A. Palmer. Dr. Jelm gave an illustrated talk on "Transurethral Resection of the Prostate Gland". Dr. Palmer presented a paper on "An Analysis of One Hundred and Fifty-seven Caesarian Sections".—Bulletin.

Wayne County Medical Society met in regular session January 9. The program was on public health activities. Dr. W. G. Rhoten, county health commissioner, reviewed the work of his department during the past year. Other phases of health work were discussed by Dr. F. C. Ganyard, a member of the county board of health, and Dr. W. B. Turner, member of the city board of health of Wooster.—News Clipping.

Seventh District

Columbiana County Medical Society met at the American Legion Hall, Lisbon, on January 9. The newly elected officers were installed. Dr. G. A. Roose, Salem, presented a paper on "The Patient, the Physician, and the Hospital". Dr. J. Maxwell, Wellsville, was elected to membership. A supper was served following the meeting.—Guy E. Byers, M.D., Secretary.

The February meeting of the society was held on February 13, Lisbon. Dr. Lowell W. King, Salem, was the principal speaker, discussing "Ear Infections".—Guy E. Byers, M. D., Secretary.

Harrison County Medical Society has elected the following officers for the ensuing year: President, Dr. A. C. Grove, Jewett; vice president, Dr. R. P. Rusk, Cadiz; secretary-treasurer, Dr. W. C. Wallace, Hopedale; legislative committeeman, Dr. Joseph McElhattan, Freeport; medical defense committeeman, Dr. H. E. Koepke, Cadiz; delegate, Dr. Wallace; alternate, Dr. Grove.—W. C. Wallace, M.D., Secretary.

Tuscarawas County Medical Society met on February 8 at New Philadelphia. Dr. George M. Wenger, Massillon, addressed the society on "Proctology".—Bulletin.

Eighth District

Athens County Medical Society met on January 8 at the Christian Church, Athens. Dr. B. R. Goldsberry presented a paper on "Agranulocytic Angina", which was well received.

At its February 5 meeting at Nelsonville the society was addressed by Dr. Jonathan Forman, Columbus, on "Hay Fever, Asthma and Allied Conditions".—T. A. Copeland, M.D., Secretary.

Fairfield County Medical Society has elected the following officers for the ensuing year: President, Dr. L. E. Stenger, Lancaster; vice president, Dr. M. E. Nichols, Lancaster; secretary-treasurer, Dr. C. W. Brown, Lancaster; censor, Dr. J. F. Farley, Lancaster; legislative committeeman, Dr. Clark G. Axline, Lancaster; medical defense committeeman, Dr. B. H. Biddle, Sugar Grove; delegate, Dr. R. H. Smith, Lancaster; alternate, Dr. C. H. Hamilton, Lancaster.—C. W. Brown, M.D., Secretary.

Guernsey County Medical Society was addressed on January 18 by Dr. Gordon Lawyer on "Treatment of Uncomplicated Early Syphilis". The report of the program committee, scheduling papers for the entire year, was approved. Members of the committee are Dr. Reo Swan, Dr. C. R. Johnson and Dr. Fred Lane. It was announced that on March 1 the society would be entertained by the Wells Hospital.

On February 1, the society was addressed by Dr. C. R. Johnson on "Interesting Events in My Practice", in which he reviewed many unusual experiences of his 36 years' practice.—News Clipping.

Licking County Medical Society was addressed on January 26 by Dr. A. M. Steinfeld, Columbus. Dr. Steinfeld presented an illustrated lecture on "Common Orthopedic Conditions". Officers for the ensuing year were installed as follows: President, Dr. George H. Brown, Hebron; vice president, Dr.

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Geraldine Crocker, Granville; secretary-treasurer, Dr. George A. Gressle, Newark; legislative committeeman, Dr. W. E. Shrontz; medical defense committeeman, Dr. C. G. Bozman; delegate, Dr. E. A. Moore, and alternate, Dr. Roland Jones.—News Clipping.

Morgan County Medical Society met January 16 at the Kennebec Hotel. Dr. W. L. Cruise, Zanesville, was the guest speaker. He reviewed his recent trip through several European clinics.—News Clipping.

Perry County Medical Society met on January 15 at the Park Hotel, New Lexington. Dr. W. D. Porterfield, Junction City, presented an interesting paper on "Burns and Their Treatment".—News Clipping.

Washington County Medical Society was addressed by Dr. Wayne Bronaugh on "Abdominal Pregnancy with Case Report" at its meeting on February 14 at the Marietta Memorial Hospital. Two reels of motion pictures were shown and described by the essayist.—Bulletin.

Ninth District

Hocking County Medical Society met in regular session January 30 at Gabriel's Restaurant, Logan. Dr. C. H. Creed, superintendent of the Athens State Hospital, was the guest speaker. He discussed "Admission, Care and Discharge of Patients at the State Hospital".—News Clipping.

Lawrence County Medical Society held its annual dinner meeting January 4 at the Hotel Marting, Ironton. After a frog dinner, the society was addressed by Dr. W. F. Marting, Dr. Oscar H. Henninger, Dr. Ralph Massie and Dr. V. V. Smith. Dr. Dan Webster presided as toastmaster.—News Clipping.

Scioto County—The Hempstead Academy of Medicine was addressed on February 12 by Dr. Francis Scott, Huntington, West Virginia. Dr. Scott discussed "Fractures". A buffet supper was served following the program which was in charge of Dr. J. W. Daehler.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)
(George J. Heer, M.D., Secretary Pro Tem.)

February 5—General Session. Program: "Recent Studies on the Relation of Diet and Dental Caries (illustrated)", Martha Koehne, Ph.D., research associate in nutrition, University of Michigan.

February 12—General Session. Program: "Symposium on Treatment of Diabetes Mellitus"; "Medical", Dr. Max P. Kanter; "Surgical", Dr. H. E. Boucher; "Eye Complications", Dr. Claude S. Perry; discussions by Dr. George I. Nelson and Dr. W. Eugene Masters.

February 19—Clinical meeting at White Cross

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February 26—General Practitioners' Section. Program: "Diagnosis of Upper Abdominal Lesions with Presentation of an Unusual, Undiagnosed Case", by Dr. E. E. Smith, Dr. Edward Campbell and Dr. H. L. Reinhart. Dr. Smith made the case report; Dr. Campbell discussed the diagnostic possibilities, and Dr. Reinhart presented the pathological discussion.

Pickaway County Medical Society met on February 2 at the Berger Hospital, Circleville. The program was presented by Dr. G. D. Sheets and Dr. D. V. Courtright. Dr. Sheets discussed "Placenta Previa". Dr. Courtright read a paper on "Review of 1,000 Obstetrical Cases".—News Clipping.

Ross County Medical Society met in regular session January 4 with a good attendance. Dr. J. E. Greiwe, Cincinnati, was the guest speaker. He presented an interesting paper on "Self-Regulatory Mechanism of the Heart".

On February 1, the society was addressed by Dr. Louis Feid, Cincinnati. His subject was "Benign Uterine Hemorrhage and Its Treatment". It was most instructive and well received.—W. C. Breth, M.D., Secretary.

Deaths in Ohio

Howard Hodson Austin, M.D., Springfield; Eclectic Medical College, Cincinnati, 1903; aged 54; member of the Ohio State Medical Association and the American Medical Association; died January 16 of heart disease. Dr. Austin was coroner of Clark County for twelve years and was a first lieutenant in the medical corps during the World War. For many years Dr. Austin was associated with his father, the late Dr. J. M. Austin. He was a member of the American Legion, Masonic Lodge and the Springfield Country Club. His widow and one son survive.

William Wesley Baker, M.D., St. Paris; Toledo Medical College, 1885; aged 73; died February 3 of paralysis. Dr. Baker retired in 1927 following many years of practice in Casstown, moving to St. Paris to reside with a daughter. Surviving are one son and one daughter.

David Bigger Best, M.D., Skotlan, near Bridgeport; Rush Medical College, Chicago, 1889; aged 73; member of the West Virginia State Medical Association and a Fellow of the American Medical Association; died January 11. Dr. Best had practiced in Wheeling, West Virginia, for many years before retiring and moving to his summer home near Bridgeport. He is survived by his widow, one daughter, two sisters and two brothers.

John Newton Calhoon, M.D., Lisbon; Western Reserve University School of Medicine, 1876; aged 80; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 11 of pneumonia. Dr. Calhoon had practiced in Lisbon for 45 years and prior to that time in Fairfield and Elkton. He was a member of the Presbyterian Church, Odd Fellows and Knights of Pythias lodges. Surviving


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Amplias Milton Countryman, M.D., Cincinnati; Pulte Medical College, Cincinnati, 1881; aged 79; died January 15. Dr. Countryman retired a year ago after fifty years of practice in Cincinnati. He was a member of the Masonic Lodge and the Congregational Church. His widow, two sisters and one brother survive.

Mary Cromer, M.D., Greenville; Miami Medical College, Cincinnati, 1904; aged 67; died February 2 of chronic arthritis. Dr. Cromer formerly practiced at Union City, Indiana, retiring in 1920.

Alton P. Gorman, M.D., Columbus; Eclectic Medical College, Cincinnati, 1928; aged 30; died January 31 following an extended illness. Surviving are his mother and one sister.

Crittenden A. Hawley, M.D., St. Paris; Miami Medical College, Cincinnati, 1891; aged 79; died February 4 following an extended illness. Dr. Hawley had practiced at St. Paris for the past thirty years. He was a former county coroner and health officer of Jefferson Township. Dr. Hawley was a member of the board of education and an active worker in the Methodist Episcopal church. Surviving are his widow, two daughters, two sons, one sister and one brother.

Samuel B. Hays, M.D., Columbus; Kentucky School of Medicine, Louisville, 1892; aged 67; former member of the Ohio State Medical Associatiohn and the American Medical Associaton; died January 19 of pneumonia. Dr. Hays had practiced at Newcomerstown and Kennonsburg before moving to Columbus fifteen years ago. He was a World War veteran. Surviving are his widow, three sons, one of whom is Dr. J. M. Hays, Columbus, and two daghters.

Theodrick M. Johnson, M.D., Lima; Hahnemann Medical College and Hospital, Chicago, 1884; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died January 31 of uremic poisoning. Dr. Johnson had practiced in Lima for many years and until recently was active in the affairs of the Academy of Medicine of Lima and Allen County. Surviving are one daughter, one brother and two sisters.

Hugh Torrence McLaughlin, M.D., Steubenville; State University of Iowa College of Medicine, 1881; aged 78; died January 29 of heart disease. Dr. John McLaughlin was for many years a medical missionary in Egypt for the United Presbyterian Church. In 1913 he opened an office in Steubenville, retiring in 1928. His widow and one brother survive.

John J. Moffett, M.D., Greenville; University of Colorado School of Medicine, 1912; aged 48; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died January 10 of self-inflicted gunshot wounds. He had been in poor health for the past

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In discussing the treatment of decomposition Feer says: "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—*E. Feer: Text-Book af Pediatrics, J. B. Lippincott Ca., Phila., 1922, p. 284.*

In the treatment of infantile atrophy Fischer recommends the following: "The carbohydrate should be increased by gradual addition of dextri-maltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—*L. Fischer: Diseases af Infancy and Childhood, F. A. Davis Co., Phila., 1925, V. 1, p. 285.*

Concerning the treatment in the case of a premature infant Fischer states: "Dried milk with water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextrimaltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at the end of the first week."—*L. Fischer: Clinical nates in a series of premature infants, Arch. Pediat. 44:227-231, April, 1927.*

Grulee, in discussing the treatment of decomposition says: "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours; the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—*C. G. Grulee: Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 265.*

Referring to the hypotrophic infant Herrman writes: "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritianal disorders in artificially-fed infants, New York M. J. 114:158-160, August, 1921.*

In discussing artificial feeding in athrepsia Hess states: "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weight are added."—*J. H. Hess: Feeding and the Nutritional Disorders in Infancy and Childhaad, F. A. Davis Co., Phila., 1928, p. 278.*

Concerning the treatment of marasmus Hill says: "When the stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—*L. W. Hill: Practical Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 281.*

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—*M. Jampolis: Infantile spasmophilia, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov. 1918.*

With reference to the treatment of diarrhea Lust writes: "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—*F. Lust: The Treatment af Children's Diseases, J. P. Lippincott Co., Phila., 1930, p. 145.*

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—*L. G. Parsans: Wasting disarders of early infancy, Lancet, 1:687-694, April 5, 1924.*

Pearson and Wyllie in discussing the treatment of milder cases of inanition says: "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—*W. J. Pearson, and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Son & Co., Phila., 1930, p. 116.*

Regarding the treatment of the marantic infant Raue states: "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—*C. S. Raue: Diseases of Children, Boericke & Tafel, Phila., 1922, p. 427.*

In discussing the treatment of atrophy Thursfield and Paterson, state: "If the baby continues to improve, the next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose . . . —*H. Thursfield and D. Paterson: Diseases af Children, William Wood & Co., 1929, p. 105.*

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, p. 158.*

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—*L. H. West: Low fat, high starch evaporated milk feeding for the marasmic baby, Arch. Pediat. 48:189-193, March, 1931.*

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—*O. H. Wilsan: The rale of carbohydrates in infant feeding, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.*

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OHIO STATE NURSES' ASSOCIATION, 50 East Broad Street, Columbus, Ohio

three years. He is survived by two daughters, two sisters and one brother.

Nathan Ramsey Simmons, M.D., Toledo; Hahnemann Medical College and Hospital, Chicago, 1884; aged 79; died January 28. Dr. Simmons had practiced in Mansfield for many years before moving to Toledo. He is survived by his widow and two brothers.

Bryant M. Tower, M.D., Conneaut; Western Reserve University School of Medcine, 1883; aged 76; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died January 9 at his winter home at St. Petersburg, Florida, of heart disease. Dr. Tower was Conneaut's oldest practicing physician and was active in civic and business affairs of that city. His widow and one brother survive.

—O S M J—

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—O S M J—

Dr. David A. Tucker, associate professor of medicine, University of Cincinnati, described the life and career of Daniel Drake, first medical student west of the Alleghanies and one of the West's greatest pioneer physicans, in an address at the University Hospital, Columbus, under the auspices of Alpha Omega Alpha, honorary medical fraternity.

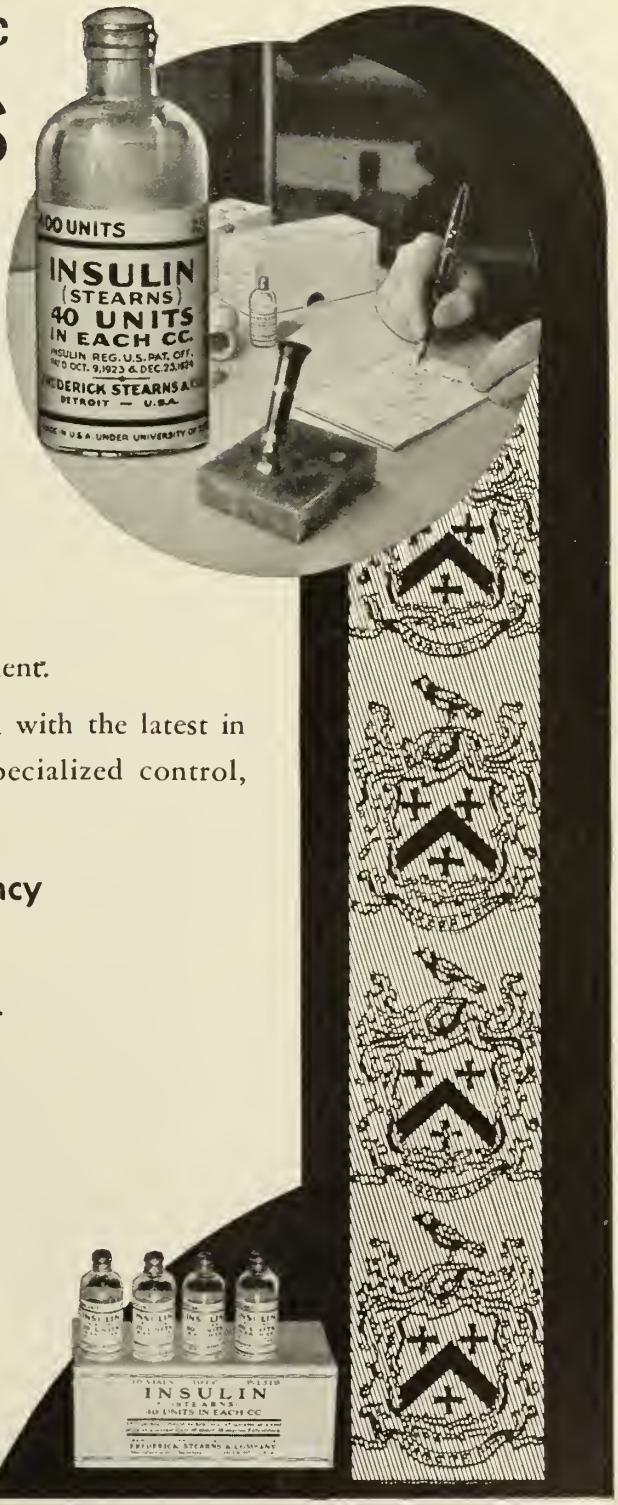
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APRIL 1, 1934 VOLUME XXX
Number 4

Important Developments in Medical Relief Situation, Including Actions By The Council and Increase in Fee Schedule By Relief Commission, Summarized in This Issue, Pages 242 to 247

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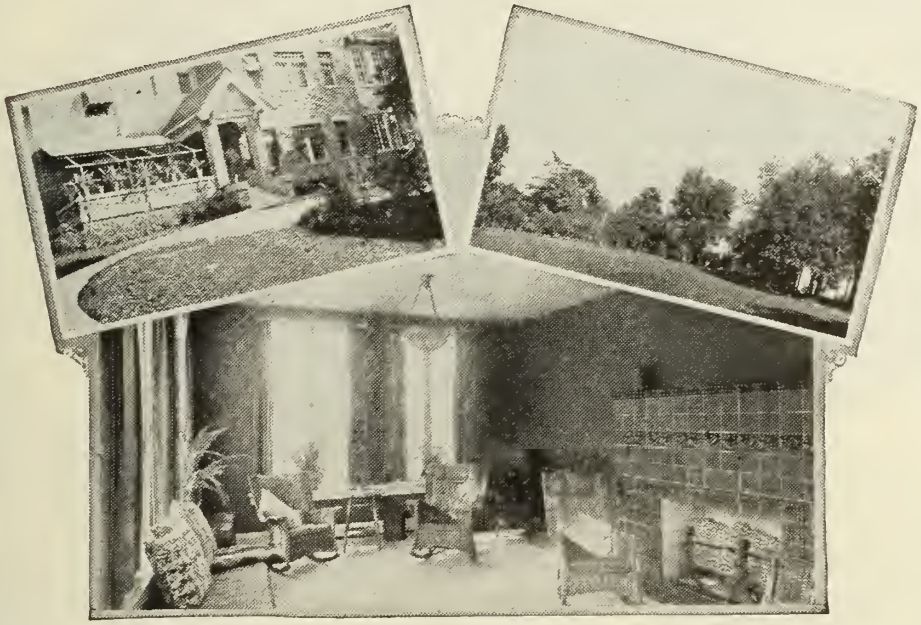
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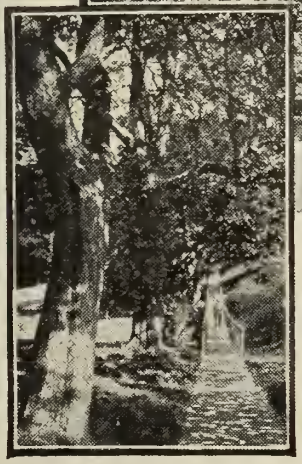
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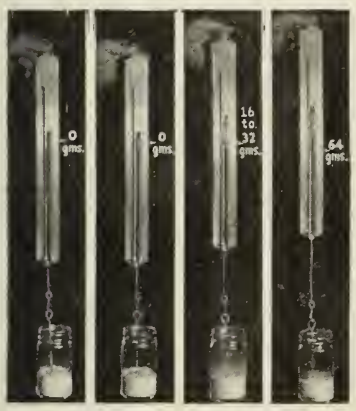
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[1] Marriott: Infant Nutrition, pg. 49.

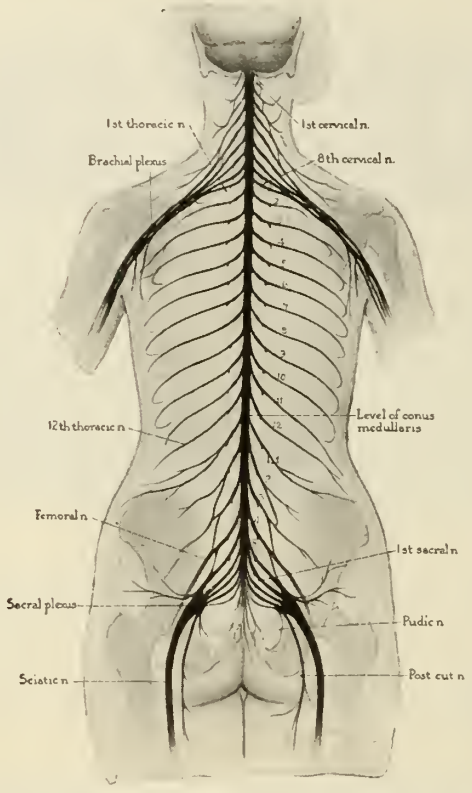
[2] Talbot: Morse and Talbot, Diseases of Nutrition and Infant feeding, pg. 48.

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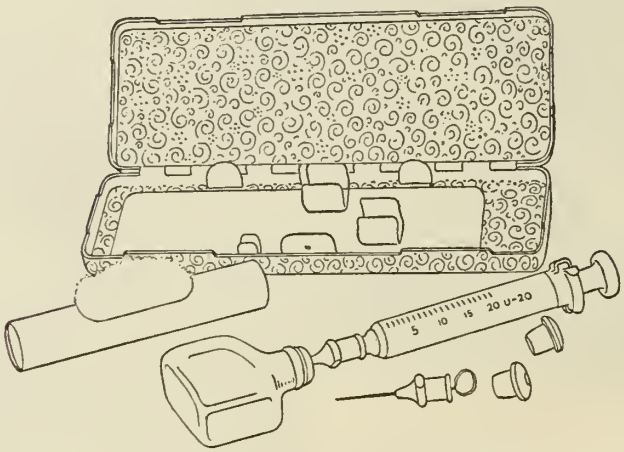
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

First-hand knowledge of the workings of socialized medicine in England is being obtained by two official observers sent there for that specific purpose by the Michigan State Medical Association.

Importance of Organization Membership

Obviously, the medical profession of that and other states will await with great interest the findings and report of this commission.

In a recent letter to Dr. F. C. Warnshuis, Grand Rapids, secretary of the Michigan society, Dr. Henry A. Luce, one of the investigators, described some of his experiences in studying the British medical insurance set-up.

In his closing paragraph, Dr. Luce made this pertinent observation, which is in effect a challenge and warning to the medical profession of this country:

"As we view the matter from both sides of the water, the importance of medical organization looms infinitely more vital. British medical successes and failures have been due respectively to organization and disorganization. Encourage every member of the profession to remain loyal and steadfast in his society affiliations."

Dr. Luce's plea after intimate observation of the British system of medical practice should add considerable emphasis to the repeated advice of the leaders of the American medical profession that only through strong, harmonious and effective organization and concerted activity will the physicians of this country be able to maintain their professional independence and retain their leadership in medical affairs.

—O S M J—

The above headline prefaced the comments of Merle Thorpe, editor of *Nation's Business*, on current economic, social and governmental developments published in the March, 1934, issue of that publication.

Ideas Must Be Free!

The meaning of this four-word sermon is perfectly obvious to anyone with a knowledge, however scant, of American history.

However, Mr. Thorpe supplements it with a brief, but pithy, description of how American initiative, "accelerated by the incentive of profit", has for almost 150 years been remaking the world. He listed a few of the contributions produced by American inventive genius and developed by American promotional skill.

Referring to these contributions and pointing out the hazards of any program or programs which would "suffocate or chill business initiative", he concluded:

"This birth of ideas and, more important, the development of those ideas into actual use, have been stimulated by the promise of reward to the successful. If these rewards are to be levelled down to the all-inclusive impersonality of the State as the collector and distributor of the people's savings, the danger is that ideas will be correspondingly devalued and the desire to get ahead deadened. That thought is variously articulated today. There is a fear that encroachments of profits may discourage business to such a degree that recovery will halt, that socialistic practices will be accepted on the showing of authority rather than by a sober consideration of all the people. Would the State—*should the State*—feel as free to risk tax money on the development of stream-lining as individuals cooperating voluntarily? Would there not at least be a lag, a disheartening delay?

"There is much concern for freedom of the press. There should likewise be anxiety for the freedom of ideas and for the freedom to develop those ideas. It takes no partisan of the old deal to see that as long as men 'do not believe that enterprise is possible they will inevitably do the very things which discourage it most. And without enterprise you do not get recovery under a capitalist system or, for that matter, under any economic system'."

The warning which Mr. Thorpe sounds for business and industry applies, we believe, with as great, if not greater, force to scientific and professional pursuits—medicine, for example—where individual initiative and enterprise and the freedom to develop ideas and stimulate mental activity are dominant factors in producing benefits that lead to progress and greater human service.

It is not difficult to imagine the results should some of the fantastic programs which have been suggested to "revolutionize" medical practice be adopted. Under them, initiative and enterprise in medicine would be suffocated, or chilled to such a degree that retrogression would promptly supplant progression which has ever been the goal of the medical profession.

Collection Problems

Collection of accounts, even in good times a bugaboo for the average physician, has become a matter of serious concern to practically every physician because of the general economic situation.

Many physicians have been compelled to take almost desperation measures to collect enough money to meet their monthly overhead. Every physician undoubtdly has given the commercial side of medical practice more thought and study during the past few years than ever before.

Because of the critical situation now confronting the profession and because most physicians are giving serious thought to their ledgers and files—a thing which many of them neglected in more prosperous times—some comments on collections and methods of collecting accounts by Dr. R. G. Leland, director of the Bureau of Medical Economics, American Medical Association, and published in the March issue of *The A.M.A. Bulletin*, are especially pertinent.

A point stressed by Dr. Leland and we believe to be of particular importance is the danger of discarding dignity and alienating the good will of patients which is inherent in most "desperation" measures to collect fees. Dr. Leland particularly warns physicians against signing collection agency contracts, especially contracts which transfer title to the accounts from the physician to the collection agency.

"Contracts which transfer title to the accounts," Dr. Leland said, "not only remove from the physician the ownership and control of the accounts, but they also make it possible for agencies to use methods of collection that disgust, intimidate and infuriate the patient and that are beneath the dignity of the medical profession. Such methods almost invariably result in the loss of confidence in and good will toward the physician. This type of collection agency is interested in volume of business, in rapid turn-over of accounts and in high profits with the lowest possible operating costs; it is not concerned with the personal relationship between patient and physician, or any of the other social values involved in private medical practice."

Dr. Leland points out that 17 county medical societies and academies of medicine have organized and are now operating their own credit and collection bureaus, and that "thus far these endeavors seem to have met with a considerable degree of success".

"Two outstanding characteristics seem to prevail," he said, "in these professionally owned and operated agencies: An effort is made to retain for each physician the respect, confidence and good will of all those who owe him for services, and the physician has control over the methods which are used in urging payment of his accounts. These methods embody more dignity than is found in many commercial methods. Thus, many persons who might 'shop around' because of a disgust engendered by 'strong arm' collection methods, continue to employ the physicians whom they still owe and express genuine appreciation over an opportunity to reestablish their medical credit."

It is suggested by Dr. Leland that physicians be careful in their charges and frankly discuss the matter of fees with their patients, in order to avert future misunderstandings or unpleasant situations.

In conclusion, he made this admirable recommendation:

"The collection of medical accounts during general economic crisis requires no less tact, promptness in presenting bills, accuracy in evaluating ability to pay, and careful selection of collection methods than during times when money is more plentiful. It is befitting the medical profession that in the collection of fees for service, the methods used be characterized by a similar degree of courtesy, prompt attention and dignity that characterizes the medical service itself. Physicians cannot be too cautious in the selection of collection methods and agencies. The choice must be made between modern ethical business practices which retain professional respect, and unfair, unethical, undignified, humiliating and almost illegal means which destroy confidence and good will."

—O S M J—

No Monopoly on Medical Treatment

No one physician or institution has or ever will have a monopoly of talent and facilities for the treatment and cure of disease.

Occasionally, however, a different impression is given to the public, often without intent to mislead on the part of those sincerely interested in spreading information concerning public health and medical matters, but as a result of a lack of understanding of the public mind with regard to such questions.

The point is splendidly illustrated in the following comment made by the editor of *Southern Medicine and Surgery:*

"For many months we have been made ill-at-ease by the great and varied publicity given Warm Springs, Georgia, as a place offering unique facilities for bringing about recovery from the sequelae of anterior poliomyelitis.

"We are uttering no word of disparagement of the place or of those in charge, of the methods of treatment or the methods of directing attention to the cures wrought there. That side of the shield we pass. But there is another side.

"It is inevitable that many will be given the impression that the treatment at Warm Springs is far and away better than that obtainable any-

where else, that the chance of complete recovery of any child crippled by this disease will be greatly enhanced if parent or guardian will take the child from under the care of the doctor now seeing after him, no matter who, and send him forthwith to Warm Springs. It is inevitable that many will assume that there is something curative in the waters of these springs, which is not in, and can not be put in, any water anywhere else.

"Consider the mental attitude of the parents of crippled children, who, as the parents must see it, will remain crippled for life solely because they can not send them to the Georgia place of healing. In their agony and despair theirs must be a lament of a bitterness like to that of Martha: 'If thou hadst been here, my brother had not died.'

"When we deliberate, we know that the doctors in charge of the patients at Warm Springs eagerly give out to the whole profession everything they know of treatment; and we know that water anywhere can be made the same as that at Warm Springs—in temperature, in chemical composition, in everything!

"In the place of a layman of average reading and having a child crippled by the disease that crippled the President, we would get that child to Warm Springs for treatment if we had to get the necessary funds at the point of a pistol.

"Having more opportunities to know the true state of affairs, if a child of ours were so afflicted we would have it treated right here in our home town—and it would be the same if we lived in Asheville, Winston-Salem, Greensboro, Durham or Raleigh; in Richmond or Charlottesville; in Greenville, Columbia or Charleston. If we lived hard-by Warm Springs we would seek treatment there for our afflicted child.

"The time can never come when all those afflicted with any one disease can be treated at any one place. It is highly improbable that any one place will ever be very greatly superior to a great many other places as a place of cure for any disease. It is the extreme in heartlessness to give the parents of crippled children the impression that a certain treatment which is beyond their treatment there for our afflicted child.

As intimated in the foregoing observation, every physician is and should be sympathetic toward health and medical activities whose worthwhileness can be judged on the basis of public benefit and need, with due consideration for the philanthropic purposes motivating them. However, it is the duty of the physician to endeavor to keep his patients in line with straight thinking on such matters. Because of his scientific training and undertsanding of the mental state of the sick, he is in a strategic position and able to assist the public in protecting itself against the inevitable results of misunderstandings and over-enthusiasm in medical and health matters.

"Do's" and "Don'ts"

A writer in a recent issue of the *New Eng. Journal of Medicine* tabulated some of the "do's" and "don'ts" which in his opinion should be adhered to by the physician interested in making a success of his career.

Perhaps the suggestions are in some instances too theoretical to be of great value and perhaps important principles have been overlooked. Nevertheless, for the sake of stimulating thought —perhaps discussion—the recommendations are herewith reproduced with the idea that they may prove of some interest or even benefit to younger members of the profession in Ohio who have not as yet learned some of the lessons which years of practice and experience can teach:

The family physician:

Don't treat something you do not understand without expert advice.

Don't fail to be frank with your patients.

Don't fail to talk their language.

Don't fail to write out instructions.

Don't fail to consult the nurse on the case.

Don't talk "shop" to patients.

Don't tell patients how good you are.

Don't fail to have outside interests.

Don't have financial dealings with patients.

Don't keep moving from town to town; select your location carefully and then stick.

Don't fail to show the spirit of service.

Practice firmness, fairness and frankness; don't show temper.

Accompany the patient to the specialist when possible; this stimulates confidence in the patient; the specialist will benefit from a conference with you.

Be neat and clean in your personal appearance.

Give more time to the convalescent stage of the illness.

Show cheerfulness and encouragement in your work.

Be fair to your professional rivals.

The specialist:

Don't work alone; find out who the family physician is when possible.

Don't fail to have close contact with the family physician.

Don't omit the written reports to the physician.

Don't disregard the patient's story.

Don't necessarily form conclusive opinion on single visit evidence.

Don't object to a second opinion in obscure cases.

Don't overcharge.

Don't fail to show the spirit of service.

Be considerate of patient's and family's reaction to your opinion.

Select your words with care.

Don't make your conferences with fatigued patient too long.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

Some day while life is running along smoothly and you think you are at peace with the world, you may be shaken from complacency by a notification couched in legalistic phraseology that you must defend yourself in an action for professional malpractice. Perhaps the damages demanded would wipe out all your savings, and in addition, mortgage your future. What would you do about it?

If you are a member of this Association, you should immediately notify our headquarters office at Columbus which will advise you as to the steps to be taken. If you carry professional malpractice insurance, you should notify your insuring company also without delay.

The service rendered by this Association to its members is called Medical Defense. It is not insurance in any sense of the word; no indemnity is paid; if damages are assessed against a member, the Association assumes no liability to assist him in payment. But the Association will assist in the defense of all qualified members, and for those not covered by insurance, it provides and compensates legal counsel. This service was inaugurated by your Association seventeen years ago; it alone is well worth the annual dues.

In recent years the number of suits and threats of suits against doctors has increased steadily. Indeed, there has been some danger of the development of another "racket". Therefore it is timely and important to call attention to some teachings of the Committee on Medical Defense. I shall quote freely and often literally from annual reports, hoping that this advice may be of service in reducing the incidence of unwarranted suits.

First, as stated often, many suits arise from the ill-advised and unjustified comments of colleagues. A physician must always be exceedingly reserved about criticizing the results of another physician, if for no reason other than his ignorance of the circumstances under which this colleague labored. Further, he must always remember that if he furnishes the spark for the instigation of a malpractice suit, he himself may be the next victim of an epidemic of such suits, and further, that any unfavorable publicity given to the profession because of his ill-advised remarks constitutes a distinct reflection on his own professional standing and that of physicians as a class.

During the progress of a case whenever diagnosis, treatment, or probable outcome are doubtful, consultation should be not only welcomed but sought. If the patient or his immediate relatives are dissatisfied, it is better to retire from the case and allow the patient to select a medical attendant in whom he will have entire confidence. When the patient refuses to follow advice, even though it does not seem feasible to withdraw from his care, a record should be made of the facts and there should be reliable witnesses to the advice given and to the patient's refusal of it.

In surgical cases the operator must be certain of the competence of all his assistants and the fact that approved methods are used in the operating room. Careful records of treatment in hospital, home or office are essential.

It is important that a physician keep his knowledge up-to-date, and avoid either antiquated methods on the one hand, or new ones not yet sanctioned by adequate clinical experience on the other. "Be not the first by whom the new is tried nor yet the last by whom the old is laid aside."

The importance of *X*-ray examinations cannot be emphasized too strongly. They should be taken where indicated invariably in fracture cases or when the nature of the injury makes fracture likely, and films should be kept on file. The committee has called attention to the importance of not pushing bills for service by suing for an account until a full year has elapsed from the completion of service.

When a member is sued or threatened with suit the member should notify the State Association at once, and if served with summons, fill out and forward an application blank to the headquarters in Columbus within ten days. We repeat that medical defense is not insurance and it does not furnish indemnity. To a qualified member it offers every facility in the preparation of defense, and to those not covered by insurance, it provides legal counsel, but in case of adverse decision, the judgment must be paid by the defendant physician.

Finally it is important to remember that a member who is sued is not entitled to the Medical Defense feature of this Association if the alleged cause occurred, or if the suit was filed, during a period in which the member is or was in arrears for dues. Dues are regarded as paid only when received at the State Association headquarters in Columbus and are due on or before January 1 for the ensuing year. Therefore, to secure Medical Defense it is important that all members pay dues promptly and that they keep themselves in good standing without lapse from year to year. If you are now in arrears for the 1934 dues, it behooves you to pay them promptly.

SYRINGOMYELIA AND SYRINGOBULBIA

By ERNEST SCOTT, M.D., HARRY LEFEVER, M.D., AND MARY OLIVER, M.A.,
COLUMBUS, OHIO

SYRINGOMYELIA is a chronic and irregularly progressive disease of the spinal cord and sometimes of the brain stem, characterized by areas of gliosis and usually by elongated cavities which are independent of the central canal and located in the grey matter.

INCIDENCE

The disease appears to be more common among men than women. Of Schlesinger's 190 cases, 37 per cent were among women. There is no good evidence for its hereditary character, nor does there seem to be any geographical or occupational distribution. It is essentially a disease of the early years of life; most cases have their incidence before the age of thirty, but due to the long period of duration, the patients may live well into middle age.

Weitz, Schlesinger, and Creuschmann agree that the disease is much more frequent than is supposed—almost as frequent as multiple sclerosis—and may be present as unnoticed sensory disturbances years before the patient becomes inconvenienced and seeks medical advice.

ANATOMICAL LESIONS

The disease is primarily a gliosis with usually, but not always, elongated and irregularly branching cavities which are independent in origin of the central canal. Occasionally the central canal also undergoes proliferation of its ependymal lining and bursts into the neighboring cavity. This most often occurs in the cervical region. The cavity is usually unilateral in origin and filled with a clear fluid. Its most frequent site is dorsal to the ventral commissure, either in the grey matter of the roots of the horns lateral to the central canal, or along the dorsal septum, or in the proximal portion of one of the grey horns. The cavity may enlarge so as to distend the cord beyond its normal dimensions and compress the grey and white substance to a mere shell of tissue. In the cervical region it is prone to widen in the lateral diameter. Frequently, partial partitions and thread-like bridges, grossly resembling the wall of the cavity, cross the lumen of the cervico-thoracic cavity. Microscopically, they likewise resemble the wall and probably represent the remains of ruptured walls between cavities or between the branches of an anastomosing cavity.

The regions involved in order of frequency are: (1) the cervico-thoracic, (2) the thoracico-lumbar, (3) the lumbo-sacral, (4) syringobulbia, (5) syringo-encephalia.

In the medulla, fissures of variable extent and form occur in the substantia grisea and may extend to involve the neighboring nuclei and tracts. The direction of extension of the main cavity is generally downward and outward, cutting off the restiform body from the olivary emience.

The wall is composed of glial tissue and the cavity lined with flattened glial cells. In the more quiescent conditions and in the portions of the wall where the process is not extending, such as in the lateral walls of a cross-section, and in the lumbo-sacral regions in Case 1, the wall is densely fibrous and contains few cells. There is a sharp demarcation between the wall and the nerve tissue. At the advancing end of the cavitation and at the peripheral portions of the split, the wall is more cellular and composed of protoplasmic astrocytes, and may be so proliferative as to fold into the lumen.

In the walls and often extending into the lumen are blood vessels, the thickened adventitia of which is very striking with differential stains and which may nearly or quite occlude the lumen of the vessel. The blood vessels may elongate, perhaps in an attempt to compensate for their hyalinization. They may then project from the wall into the lumen of the cavity as tortuous knots carrying with them glial cells. As cut in section, these knots may appear as "vascular islands" composed of deeply staining connective tissue and a few glial cells. Hassin claims that these blood vessels are pathognomonic of syringomyelia. He thinks that the increased pressure of the fluid in the cord results in the tension and thickening of the blood vessels of the region. Rapidly growing portions of the wall are likely to be very vascular and then hemorrhages are often seen with phagocytic cells loaded with blood pigments and debris.

Effects on the surrounding nerve tissue are produced either through pressure or through actual invasion. In the region of the cavity there is actual destruction through gliosis and cavity invasion; the white matter may be degenerated and gliosed as a result of pressure from the expanding cavities. Degeneration of nerve cells may also be of the secondary or wallerian type through destruction of their fibers at some point.

CLINICAL CHARACTERISTICS

The clinical symptoms are as variable as the lesions in the cord and brain and correspond to the segments involved. A typical clinical picture may be: (1) initial sensory disturbances of the arms, as tinglings, formication, cold spots, numbness, (2) dissociated sensibility in which pain and temperature are lost in an area with the

Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7-8, 1933.

retention of the tactile, particularly the epicritic, sense, (3) weakness and later atrophy in the shoulder and arms; then as the lumbar segments are involved, the lower extremities may become wasted, (4) the "claw-hand" due to muscular atrophies and contractures, (5) dyspnoea, dysphagia, and dysarthria from involvement of the glosso-pharyngeal and vagus centers in the medulla, (6) oculo-motor palsies, most often that of the external recti supplied by VI, (7) nystagmus due to an involvement of the vestibular apparatus, (8) difficulties in the coordination of movements of the extremities from lesions in the proprioceptive system, the spino-cerebellar system, or the cerebro-pontine-cerebellar system, (9) interference with the finer movements of the hands and fingers from cavities formed in the posterior limb of the internal capsule at the junction of the thalamus and the corpus striatum, a common point of attack according to Spiller, (10) trophic disturbances as painless ulcers, shiny skin or joint troubles as arthropathies of the shoulder and scoliosis.

Perhaps in few other extensive diseases of the central nervous system can the clinical symptoms be so satisfactorily correlated with the anatomical lesions as in syringomyelia.

CASE REPORT

Case History: K. C., white, female, aged 25, was first admitted to the University Hospital February 13, 1933.

The chief complaints upon admission were difficulty in swallowing and unsteadiness in walking.

Family History: Father living and well at the age of 46; mother living and well at the age of 45.

Past History: At the age of four the patient had an attack of measles from which she recovered without complications. At the age of five she contracted infantile paralysis which was said to be the cause of her curvature of the spine. At the age of 14 she began to have generalized convulsions which were followed by severe headaches and vomiting. With the institution of the menses at the age of 15 the convulsions ceased and she had no further attacks. At the age of 17 she had two severe attacks of laryngitis and at the age of 19 her tonsils were removed. The patient was unmarried. The patient graduated from high school at the age of 19, following which she entered Ohio State University and was graduated in 1932. She obtained a position as assistant dietitian in a Chicago hospital. She gave up her position in September, 1932, because as she said "she could not keep up the pace".

Present Illness: The patient stated that she began to notice difficulty in walking in August, 1932. This was especially noticeable in turning around, at which time she was quite unsteady. On November 25, 1932, while attempting to swallow a morsel of toast she choked. She was not relieved of the choking sensation until she vomited. From this date until the time of admission it was more and more difficult to swallow. Liquids caused more choking than solid food. For two weeks prior to admission she had not been able to swallow liquids. About the same date that the patient noted difficulty in swallowing she also noted that the voice had become hoarse. This too increased so that at the time of admission she could speak only in a whisper. For three weeks prior to admission she was short of breath and could not breathe in the supine position.

Physical Examination: The patient was a well-developed female, weighing 162 pounds.

She was semi-sitting in the bed due to the fact that respirations became quite laboured in the reclining position. The patient could talk only in a whisper.

The general physical examination was not remarkable except for a right scoliosis of the spine. B. P. 150/90.

An electrocardiographic tracing revealed evidence of slight myocardial damage.

Neurological Examination: The patient was unable to stand erect with the eyes closed. The gait was unsteady, especially upon turning around. The coordination of both upper and lower extremities was poor. Muscle power was apparently not involved in the extremities or trunk. Sensation to epicritic pain and temperature was not involved. Pallaesthesia (vibratory sense) was not present. The deep-joint sense was markedly impaired.

No atrophy could be demonstrated.

Reflexes:

	R.	L.
Biceps	O	O
Triceps	O	O
Abdominal	–/–	–/–
Knee Jerk	–/–	–/–
A. J.	–/–	–/–
Plantar	–/– flexor	–/– flexor

Cranial Nerves:

(1) Test odors could all be identified.

(2) Vision was unimpaired. Pupils reacted to light and to accommodation. Examination of the fundi did not reveal any abnormalities.

(3-4-6) Diplopia was present upon looking to the extreme right and left. A paresis was present in both external recti.

(5) Corneal reflex was present, no anæsthesia, no deviation of the jaw.

(7) No facial weakness was present. Taste normal on the anterior two-thirds of the tongue.

(8) No tinnitus, hearing was unimpaired. No vertigo, no nystagmus.

(9) The gag reflex was sluggish on both sides and taste was absent upon the posterior third of the tongue.

(10) Headache was not present. Respirations were laboured. The pulse rate was subject to marked variation, ranging from 70 to 128. A bilateral adductor palsy present in the larynx.

(11) Normal.

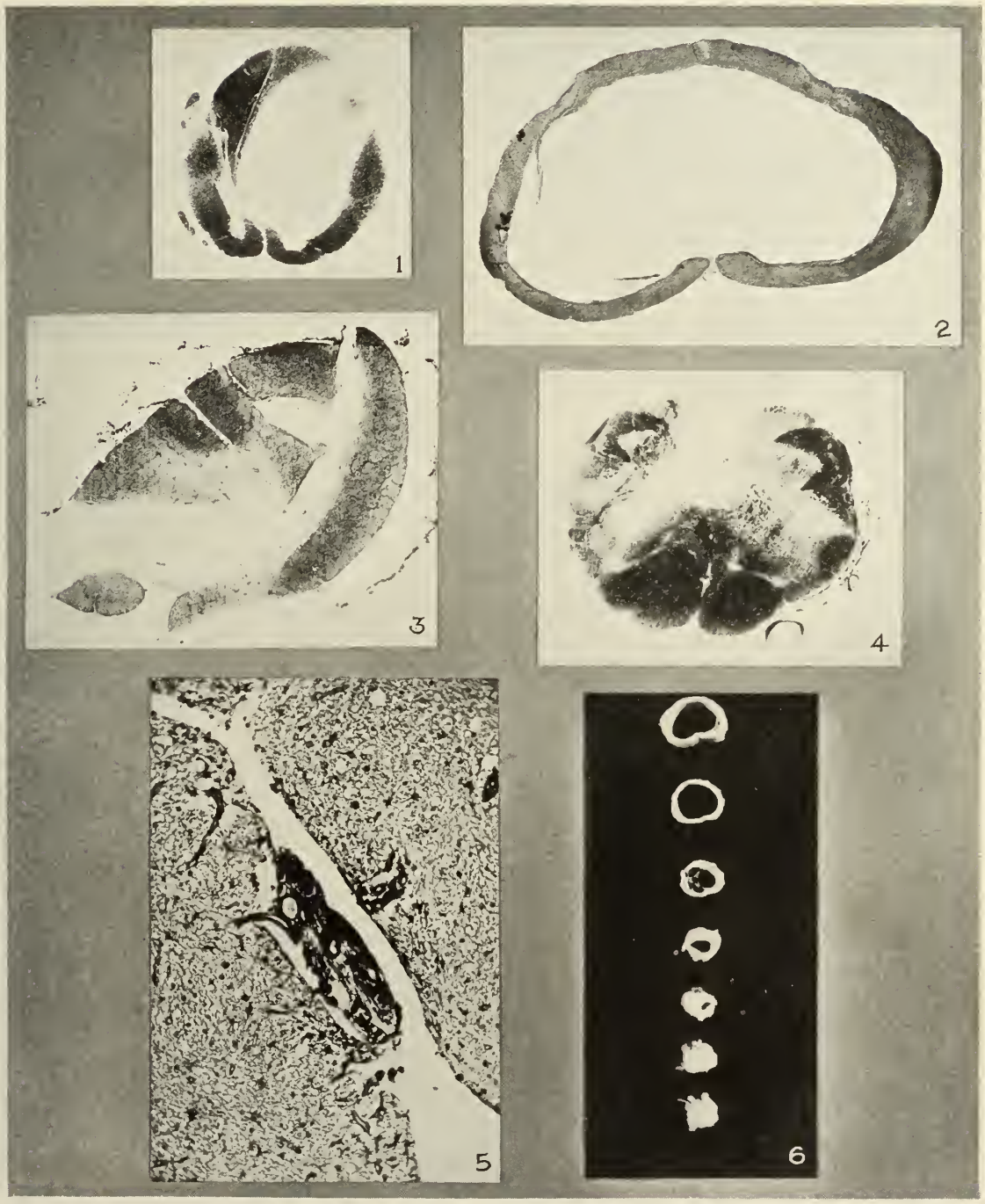
(12) Normal.

No symptoms or signs were found referable to the cerebral lobes.

Laboratory Examination: Urine negative. Blood count: red blood cells, 4.5; hemoglobin 12.8 gms.; white blood cells 11,550. Wassermann reaction was negative. Basal metabolism: 16 plus. The temperature was normal during the 13 days she remained in the hospital.

The patient was discharged February 26 with a diagnosis of *bulbar paralysis*, and *right scoliosis* of the spine.

Subsequent History: The patient was readmitted to the hospital March 9, 1933, due to the



EXPLANATION OF PLATE

Fig. 1. Section of the cord in the mid-thoracic region showing the cavity obliterating the right posterior horn and central grey matter, and compressing the anterior horn. The posterior septum is displaced to the left. Pal-Weigert stain, x 8.

Fig. 2. Section through the mid-cervical region showing the greatly expanded cavity which has involved the central canal. The destruction of the proximal portions of the sensory nerves and the degeneration of the anterior motor cells account for the loss of the biceps and triceps reflexes (C 5-6). Hematoxylin-eosin stain, x 8.

Fig. 3. Section through the upper cervical cord showing the bilateral cavity formation. The anterior horn and fissure are carried to the left. The central portions of the column of Goll, and to a less extent, of Burdach, are degenerated, thus interrupting the pathway for ascending proprioceptive impulses. Mallory's reticular stain, x 8.

Fig. 4. Section through the lower medulla at the level of the decussation of the fillet, showing the bilateral cavity formation, which cuts off the nuclei cuneatus and gracilis and involves the dorsal motor nucleus of X, the nucleus ambiguus, and the internal arcuate fibers. Pal-Weigert stain, x 8.

Fig. 5. Detail of a vascular knot of thickened vessels in the wall of the cavity in the medulla, Alzheimer-Mann stain, x 260.

Fig. 6. Blocks from the spinal cord seen in cross-section showing the formation of the cavity in the right posterior horn at the lumbar level, and its expansion at higher levels. Normal size. Entire plate reduced about one-half.

fact that for two days prior to the second admission it had been impossible to pass the stomach tube and any food which she attempted to take by mouth had regurgitated through the nose.

Due to the difficulty in swallowing a gastrostomy was decided upon. On March 11, the abdomen was opened under spinal anæsthesia and as the stomach was being opened the patient's respirations ceased and palpation of the aorta and heart showed no cardiac activity. Two cubic centimeters of adrenalin chloride was injected into the heart muscle and the organ was massaged through the diaphragm. With the first massage the heart began to beat. Artificial respiration was continued for some minutes until the patient began to breathe. The operation was then continued. At the end of the operation the patient was unconscious, the blood pressure was 60/48, and the respirations were crowing.

The patient did not regain consciousness and died that evening.

Autopsy: The autopsy was performed at 10 a. m., 3/12/33, at the University Hospital by Dr. H. L. Reinhart.

General Description of the Body: The body is that of a white female, well developed and well nourished, measuring 66½ inches in length, and weighing approximately 150 pounds. The features are large and there is a keloid-like scar on the right shoulder measuring 11.5x5 cm. The wound of a recent tracheotomy lies in the midline about 4 cm. above the sternum. There is a second bandaged wound situated vertically about 12 cm. and obliquely 5 cm. to the right of the midline above the umbilicus,—that of a recent gastrostomy. The arms, hands, thighs, knees, legs, and feet are symmetrical and without signs of edema. On the dorsal surface of the body there is a marked scoliosis to the right.

The Abdominal Cavity: There are adhesions of the stomach wall to the parietal peritoneum at the site of operation. The liver margin is level with the costal border. The transverse colon is pendulous, extending 4 cm. below the umbilicus. The spleen is normal in size and position. The right and left kidneys are small. There is an increase in fluid in the body cavities, and the intestines are empty. The urinary bladder is distended with urine. The uterus is small and to the left. The appendix is kinked.

The Thoracic Cavity: The left chest is somewhat enlarged to the right side, and there is evidence of intercostal-muscle atrophy on this side. The lungs are free from adhesions. The heart is slightly enlarged and somewhat fatty with petechial hemorrhages on the surface of the left ventricle. There is a small amount of pericardial fluid, which is clear and estimated to be about 10 cc. in amount.

Left Lung: There is edema and congestion evident in the lower lobe and some congestion at the apex.

Right Lung: Normal.

Heart: The right ventricle is slightly dilated. The mitral valve measures 75 mm., and there is some fibrosis of the cusps but no vegetation. In the aorta there are two small plaques in the ascending and transverse portions without any particular arrangement.

Spleen: The spleen weighs 200 grams. It has a deep notch on the surface and cuts with increased resistance. There is an evident increase in Malpighian bodies.

Kidneys, ureters, and adrenals all are normal. The left kidney retains its fetal markings. *Mesenteric lymph nodes* are moderately enlarged and somewhat caseous in type.

Uterus: The uterus is small and measures approximately 4 cm. in diameter. The wall measures 1.5 cm. in thickness. The cervix shows areas of erosion.

Left Ovary: The left ovary measures 3 cm. in diameter. There is an involuting cyst measuring 1 cm. in diameter, a small parovarian cyst measuring 1 cm. in diameter. There is evidence of a nearly mature follicle.

Gastro-Intestinal Tract: There is a marked dilatation of the cecum with some diverticuli in the cecum and ascending colon. There is increased solidification and calcification of the lymph follicles in the cæcum and ileum, also an increase in size of Peyer's patches. The stomach shows evidence of a gastrostomy wound, but otherwise is not remarkable.

Cranial Cavity: The removal of the calvarium reveals areas of rarefaction and erosion of bone by the Pacchionian granulations. The dura is not thickened. There is an increase of fluid in the subarachnoid space, and a marked thickening of the Pacchionian granulations. The cerebral hemispheres appear larger than normal. The vessels of the brain are generally dilated especially on the right side. The tentorium cerebelli is dissected with difficulty and the cerebral hemispheres removed by supratentorial section. The cervical cord is removed via the foramen magnum with difficulty due to firm adhesions of connective tissue binding the cord to the foramen. There is a marked dilatation of the cervical cord with but a shell of medullary tissue around the cystic dilatation.

Gross Pathology:

Brain: Upon opening the ventricles, a marked increase in clear fluid is found which escapes under pressure. The lateral ventricles, third ventricle, and aqueduct of Sylvius are considerably dilated (hydrocephalus). Sections through the medulla, pons, and cervical cord reveal small fissures in the medullary substance.

The meninges do not appear thickened.

Cord: The cervical cord is markedly enlarged in a transverse diameter and measures 2 cm. in the lateral diameter and 1.2 cm. in the antero-posterior diameter. The shell of cord tissue which remains is 1.5 mm. in thickness. The lumen of the cavity gradually becomes smaller as it descends through the thoracic region to become a unilateral slit in the right posterior horn. Throughout the cervical and dorsal regions the lumen of the cavity is partially interrupted and occluded by bridges and semi-partitions of tissue which resemble the wall of the cavity. Along the line of Lissauer's tract where the tip of the right grey horn approaches the surface of the cord the wall is so thin that in places the meninges only cover the cavity. This line marks the peripheral limit of the cavity.

Blocks for study were taken from the frontal and hippocampal cortex; the lateral lobe of the cerebellum; the upper and middle cervical cord; upper, middle, and lower thoracic, middle lumbar and sacral; and the medulla and pons.

Anatomical Diagnosis:

1. Marked internal and external hydrocephalus.
2. Enlargement of the Pacchionian granulations.
3. Cystic dilatation of the central canal of the spinal cord (hydromyelia).
4. Marked thoracic scoliosis to the right.
5. Slight edema of the lungs.

6. Operative wounds; tracheotomy and gastrostomy wounds.

7. Slight enlargement of the spleen with moderate hyperplasia of the lymphoid tissue and mesenteric lymph nodes and Peyer's patches.

8. Multiple diverticuli of the cecum.

9. Small uterus with slight cervical erosion.

10. Cystic ovaries.

11. Muscular atrophy of the right rectus abdominis and intercostal muscles on the right side due to infantile paralysis or syringomyelia.

Histological Study: The brain and cord were fixed in 10 per cent formalin and blocks embedded in paraffin and in celloidin.

The following stains were employed routinely in the study of the various levels of the cord and brain: hematoxylin-eosin, Pal-Weigert method and Morgan's modification of the iron-hematoxylin method for myelin sheaths, Mallory's reticular tissue stain and Van Gieson's connective tissue stain, cresyl violet for ganglion cells, Mallory's phosphomolybdic hematoxylin method for astrocytes, Wilder's silver nitrate stain for glial fibers and astrocytes, the Holzer stain for glial fibers, and the Bielschowsky-Alzheimer-Mann and the Alzheimer-Mann stain. Blocks from typical levels of the cord and brain stem were selected for study.

Upper Sacral: The central canal reveals scattered groups of ependymal cells lying laterally to the canal in the roots of the grey horns. In the right posterior horn is a slit-like cavity which is somewhat dilated at its peripheral end but which does not extend to the end of the posterior horn. In the cavity as islands or as twisted projections extending into the lumen from the wall appear vascular knots in which the adventitia is markedly thickened. Smaller cavities, apparently continuous at other levels with the main cavity, are found in the root of the right posterior horn and in the anterior commissure. These are apparently similar to the larger cavity. The wall of the cavity is composed of glial tissue and is thicker and more cellular at the peripheral end of the slit as if the cavity had formed in preexisting glial tissue. No myelinated nerve fibers appear in this wall. Some increase in the amount of glial tissue occurs in the right posterior horn in the neighborhood of the cavity, and the nerve fibers of this horn seem somewhat degenerated as compared with those of the left. The myelin sheaths of the posterior columns of Goll and Burdach reveal a definite increase in the number of astrocytes and in the thickness of the septa. The emerging anterior roots and the anterior nerves show definite areas of degeneration. In some cases the fibers can be traced to those motor cells whose fibers are interrupted in the anterior white commissure. The fasciculus lateralis proprius adjacent to the cavity is somewhat paler in Pal-Weigert sections.

Middle Lumbar: At this level, the slit-like cavity is larger than in the preceding level and involves the right root of the grey matter and the right posterior horn. In some sections at this level as traced in Pal-Weigert sections, the anterior fissure with accompanying blood vessels extends up into the right posterior grey root. The anterior white commissure again appears slightly compressed by the cavity and the myelin sheaths are distorted.

The wall of the cavity is similar to that already described; the lateral walls of the main fissure are slightly denser in glial fibers than at the ends of the fissure, and the fibers run parallel to the circumference of the fissure. At either end of the cavity appear proliferations of glial cells sometimes forming syncytia. Cresyl violet stain employed for the study of Nissl bodies reveals a degeneration of the secondary or wallerian type in some of the motor cells of the anterior horn. On the affected side the nucleus of Stilling through which the fissure passes is largely degenerated and the ganglion cells are encircled by pericellular neuroglia. The nucleus of Stilling, a part of Clarke's column, is concerned with sending incoming muscle-tendon impulses to the spinocerebellar tract, thence to the cerebellum. It is thus concerned with the coordination of limb movements on the basis of proprioceptive impulses.

Lower Thoracic: At this level the cavity has enlarged markedly and reached the periphery of the cord but is covered by the thickened pia-arachnoid. Except in its size the character of the cavity and its wall has not changed. Blood vessels accompanying the cavity may be nearly occluded. The cresyl-violet stain for Nissl substance reveals a degeneration of the left lateral ventral-horn cells, a degeneration and neuronophagia of part of the cells of the left Clarke's column, and a nearly complete disappearance of the right Clarke's column adjacent to the cavity. The substantia gelatinosa is mostly destroyed.

Thoracic VIII: The cavity has encroached upon and largely compressed the left side of the cord as well, carrying to the left of the midline the central canal. There is almost complete destruction of the grey matter on the right side except for the right ventral mesial column. The right anterior horn is swollen and edematous.

Middle Thoracic: The cavity is still more distended, but the central canal is intact. The right grey matter shows greater distortion and atrophy. The inner wall of the cavity shows large vascular spaces and loose glial tissue, the outer part of the wall is composed of astrocytic cells cut longitudinally and stained red with hematoxylin-eosin and grey with the Pal-Weigert method. The ganglion cells of the left anterior mesial and splanchnic groups show an early degeneration, particularly of the lateral group. The right anterior motor cells have entirely disappeared. The destruction as well of much of the right posterior grey horn and of the fasciculus lateralis proprius interrupts segmental reflex arcs and impairs the thoracic reflexes on this side. This may account for the atrophy of the right intercostal and rectus abdominis muscles.

Upper Thoracic: The cavity here occupies nearly the entire volume of the cord at this level. The transverse diameter is 1.5 cm., the thickness of the cord substance and cavity is 1 mm. The cavity is still surrounded by the vestiges of the right posterior horn. The central canal is intact and ventral to the cavity. The wall of the cavity varies in thickness, becoming thinner as it approaches the dorsal border. The anterior horn cells of both sides have partially disappeared. The vascularity and glial tissue of the grey matter is increased. There is considerable replacement of myelinated fibers by astrocytes which the iron hematoxylin stain beautifully brings out. Two smaller slits are present in the wall of the main cavity, ventral to it and lateral to the central canal.

Middle Cervical: The meninges are edematous and thickened. The central cavity below the main cavity has at this level expanded and burst into the main cavity, leaving a tongue of glial tissue lined by ependymal cells, the proliferated remains

of the ruptured central canal cells. A part of the main cavity as well is lined by ependymal cells. The astrocytes in the ventral portion of the wall seem more numerous than at lower levels, the vascularity is marked, and there are numerous phagocytic microglia. The evidence points toward a more active and a younger lesion than in the lower thoracic and lumbar regions. The anterior fissure is markedly widened resulting from hydrocephalus. The anterior grey matter is very vascular. Myelin-sheath stains reveal the posterior roots to be somewhat degenerated, the ventral emerging roots entirely degenerated. The septa are thickened. The anterior and lateral white columns are slightly gliosed.

Upper Cervical: The laterally flattened cavity lies in the posterior horn and involves the central canal as in the preceding level. The cavity is more expanded to the right, carrying with it the posterior septum. In each posterior column is a secondary branch of the main cavity lined by cellular glial tissue similar to that of the main cavity. The posterior septum has been separated by the tension of cavity formation in the columns. There is a complete degeneration of the central portions of the column of Goll and to a lesser extent of Burdach with conspicuous neuroglial replacement. At this level as revealed by the reticular tissue stains there is considerable increase in the connective tissue accompanying the blood vessels, particularly in the posterior columns. The cavity, however, is at no place lined with connective tissue, although accompanying it are thickened and obliterated blood vessels with heavy connective tissue elements which at first sight might be mistaken for the lining cells of the cavity. The tissue of the wall is in places rather fragmented, in others the astrocytes are large and numerous, the blood vessels are abundant and thickened. Phagocytic cells are numerous.

There is much gliosis in the white matter throughout the cord. Ganglion cells in the anterior horns are degenerated and phagocytized.

Caudal Tip of the Medulla: This partial section includes the lower end of the decussation and the dorsal and ventral accessory nuclei which have been separated by the decussating pyramidal fibers. The central canal is again intact. Fissure-like cavities occupy the right and left posterior grey horns. The right, and to some extent the left, dorsal accessory nuclei are undergoing degeneration with neuronophagia as a result of their involvement in the glial tissue at the tip of the split. This nucleus is said to supply fibers to the recurrent vagus nerve which with the fibers of X innervate the adductor muscles of the vocal chords. This lesion is partially responsible for the hoarseness and loss of voice and the labored breathing in this case. There is no increase in connective tissue except around the blood vessels. In all stains, the loss of myelin in the decussating pyramidal fibers appears, but it is possible that this appearance is due to shrinkage in fixing.

Medulla at the Upper Part of Decussation of the Pyramids: The sections were stained by the Pal-Weigert method. The fourth ventricle is distended. The sections reveal a bilateral, slit-like cavity or fissure. At some levels the cavities are seen to connect across the midline and appear to partially destroy nucleus XII. On either side the fissure traverses the region of the dorsal X nucleus, the nucleus ambiguus, a portion of the nucleus radix spinalis V, and the internal arcuate fibers as they decussate to the mesial fillet. The internal arcuate fibers have entirely faded on one side.

Medulla through the Middle Part of the Olive: The fissure formation is conspicuous and branched and occupies much the same region as in the preceding level. The dorsal X nucleus, nucleus ambiguus, the substantia grisea, part of nucleus lateralis X and the merging fibers of X are involved. The nucleus of XII appears to be somewhat scarred. An accessory cavity involves the tractus solitarius. Marked tissue destruction has taken place with gliosis in the floor of the fourth ventricle. The wall of the cavity is composd of large astrocytes and is invaded by numerous lymphocytic cells. The abundant blood vessels at times appear to line the cavity.

Medulla through the Root of X: At this level the fissure formation is less distended but much branched. As we proceed upwards through the series in this block the cavity becomes narrower and shorter, the wall composed of more immature astrocytes. At all levels the fissure is so directed that the process reaches the concavity of the medulla between the restiform body and the olivary eminence. It involves the same structures as above. Except in the middle sections of this level the nucleus and tractus solitarius seem intact.

Medulla through the Radix IX: At this level the branched cavities are very narrow and on the one side consist of scarcely more than the astrocytic cells among the cells of the nucleus ambiguus.

Pons at the Level of Nucleus of VI and the Roots of VII and VI: The rootlets of VI appear somewhat degenerated but as far as could be seen the nucleus of VI appears normal. There is distinct degeneration of many fiber-tracts in the brachium pontis with some gliosis. This is the middle peduncle of the cerebellum and carries fibers from the descending cortical motor pathway to the lateral lobes of the cerebellum which is the coordinating center for dissociated or asynergic movements as of the arms and legs. It thus is part of the cerebro-pontine-cerebellar system which is concerned with the coordination and equilibration of voluntary motor impulses.

Sections from the Pons at the Level of the Trigeminus appear normal.

Pons at the Level of the Descending V Tract are normal. The brachium conjunctivum appears normal in Pal-Weigert sections.

Sections from the lateral lobe of the cerebellum, the right frontal cortex, the hippocampal gyrus all appear normal, except for a distention of the perivascular spaces about all blood vessels, which also is noticeable in the cord and medulla. This condition is doubtless associated with the existing internal hydrocephalus.

NEUROLOGICAL DISCUSSION

The period during which the patient noticed and was seriously inconvenienced by symptoms of the disease dates from about four months prior to the time of her first admission to the hospital, and seven and a half months prior to the time of her death.

In the following tabulation it is attempted to correlate the neurological symptoms with the corresponding anatomical lesion. The symptoms are given as nearly as possible in the order of the time of appearance.

SYMPTOMS	ANATOMICAL LESION	TRACT AND FUNCTION
Unsteadiness in gait, especially upon turning around.	Partial glial scarring in the columns of Goll and Burdach in the lumbar region.	Proprioceptive (muscle-tendon and joint sense) for cord reflexes and movements concerned with sensations of posture, spatial discrimination, and the coordination of movements of precision, in this case in the limbs.
	Bilateral degeneration of the proximal portions of the columns of Goll and partially of Burdach in the upper cervical region.	
	Total loss of internal arcuate fibers on one side and partial loss on the other at the level of the decussation of the fillet, due to their interruption by the cavity and the degeneration of the columns of Goll at the upper cervical level.	
	Interruption of the rubrospinal tract in the medulla.	A pathway concerned with coordination of involuntary and voluntary movements based on: (1) impulses from the lateral lobes of the cerebellum (asynergic movements) via the dentate nucleus-brachium conjunctivum-red nucleus and, (2) impulses from the thalamus and cortex to the red nucleus.
	Degeneration of bundles of fibers from the cortex in the brachium pontis.	Part of the cerebro-pontine-cerebellar system which brings under the coordinating control of the cerebellum voluntary motor impulses from the cortex.
Increasing difficulty in swallowing.	Progressive destruction of the cells of the nucleus ambiguus in the medulla (spec. visceral motor nucleus of IX and X) supplying fibers via motor IX (r. stylopharngeus IX) to the pharyngeal muscles.	
Hoarseness of voice and loss of voice.	(a) Destruction of cells in the dorsal accessory nucleus (XI) with fibers to the recurrent vagus nerve at the level of the decussation of the pyramids.	To the voluntary adductor muscles of the vocal cords.
	(b) Destruction of a large part of nucleus ambiguus in the medulla (spec. visceral motor nucleus of IX and X) by the cavity formation.	To the voluntary adductor muscles of the vocal cords.
Dyspnea (extreme)	Destruction of cells in the nucleus ambiguus supplying fibers to the recurrent vagus.	To adductors of the cords.
Poor coordination of the upper and lower extremities.	Lesions in the posterior funiculi in the upper cervical region and the internal arcuate fibers.	Proprioceptive control of coordinated movements (see unsteadiness of gait)
	Lesion in the rubro-spinal tract.	See unsteadiness in gait.
	Destruction of part of Clarke's column on left and entirely on the right in the thoracic region.	Spino-cerebellar relay of fibers from lower extremities and thoracic muscles carrying muscle-tendon impulses concerned with the coordination of involuntary movements based on proprioceptive impulses.
Externus rectus palsy (bilateral)	Degeneration of the emerging VI nerves.	
Gag reflex sluggish.	*Sensory half of arc:*	
	Partial lesion of nucleus tr. solitarius by the cavities in the medulla (general visceral sensory nucleus receiving fibers from IX and X)	Part of the mechanism concerned with the vomiting and gagging reflexes.
	Motor half of arc:	
	Destruction of nucleus ambiguus sending motor fibers via IX root. At this level there is less destruction of nucleus ambiguus, and the reflex is not entirely abolished.	
	Probably the lesion is chiefly in the motor half of the arc.	
Atrophy of the right intercostal and right rectus abdominis muscles.	Partial loss of the right anterior or motor cells in segments Th 1-12 and loss of the corresponding sensory or afferent fibers in the substantia gelatinosa in the posterior grey horn.	Segmental reflexes and muscle tone.
Inability to stand erect with eyes closed.	Lesion in the columns of Goll and Burdach and in the internal arcuate fibers at their decussation to the fillet.	Muscle-tendon and joint sensibility which gives sense of position when eyes are shut.
Pulse rate very irregular (72-128)	Involvement of the dorsal X nucleus (general visceral motor nuc.) sending fibers to the cardiac sympathetic plexus of the heart.	Inhibitory and regulatory action on the heart.
Loss of deep-joint sensibility.	(1) Partial degeneration in the columns of Goll and Burdach of the cord from the lumbar region up, especially in the upper cervical region where degeneration is nearly complete in the central portions.	Joint-and-muscle-tendon sensibility concerned in reflexes and coordination of voluntary movements based on proprioceptive impulses.
	(2) Loss of internal arcuate fibers at their decussation to the medial fillet, complete on one side.	

SYMPTOMS	ANATOMICAL LESION	TRACT AND FUNCTION
Loss of taste on posterior third of tongue and probably pharynx and soft palate.	Lesion in the nucleus tr. solitarius sending fibers via IX sensory roots (special visceral sensory nucleus of IX and X)	Taste in pharynx and posterior tongue.
Biceps reflex lost bilaterally.	Loss of dendrites of entering sensory neurones in the posterior horn and the motor cells in the anterior horn in segments C 5-6.	Reflex contraction of biceps.
Triceps reflex lost bilaterally.	Loss of sensory neurones (proximal half) and the anterior horn cells in segments 6-8.	Reflex contraction of triceps.
Plantar normal (Flexion)	Reflex arc intact L 4-5, S 1-2.	
Knee-jerk normal.	Pyramidal tracts mostly preserved. Motor cells in L 3-4 intact.	
Achilles jerk.	Reflex arc intact S 1.	
Abdominal reflex	Reflex arc intact Th 8-12 normal.	

The absence of atrophy in the muscles of the arms and legs may be explained by the relatively short duration of the clinical course. Prior to the onset of the acute phase the cavitation probably existed as a relatively small slit in the right posterior horn which did not cause pressure on the motor cells of the anterior horn. Onset of the acute stage with dilatation of the cervicothoracic portion and pressure on Clarke's column and the columns of Goll and Burdach in the cervical region was marked by consequent incoordination in arm and leg movements. The location of the cavity in the cord did not involve the ventral commissure to sufficient extent to destroy the decussating fibers carrying exteroceptive sensory impulses of pain and temperature from the extremities and trunk; therefore in this case we do not have loss of pain and temperature sensibility as in typical cases.

The relatively small size of the cavity in the lumbar and sacral regions so that the anterior motor cells are not markedly involved, and the integrity of the pyramidal tracts explain the retention of the normal reflexes in the lower extremities and abdomen.

Tension on the meninges exerted by the distended cavity of the cervico-thoracic region probably accounts for their thickening and the stasis in the circulation with perivsacular dilatation. The end result was an internal hydrocephalus which existed in marked degree in this case.

PATHOGENESIS AND DISCUSSION

Syringomyelia was first recognized as a disease entity by Morgagni in 1740 and by Portal in 1800. It was described as distinct from an enlargement of the central canal by Ollivier in 1834 and given the name "syringomyelia". During the interval until 1894, when Schlesinger brought out his monumental monograph based on the study of 190 cases, its characteristic clinical syndromes and anatomical lesions were studied by many workers, chief among whom may be mentioned Schultze, Kirch, Bielschowsky, Bremer, Ostertag and J. Hoffman.

Two principal views as to the cause of the syringomyeletic condition are now widely held—the theory of a congenital malformation of the central nervous system resulting in glial hyperplasias or in gliomatosis (multiple tumor formations) and (2) a weakness and degeneration in the glial tissue with subsequent attempts at healing. We exclude from this discussion those cavity formations due to traumatic and non-traumatic hematomyelias, cavities associated with meningitis, in which the cavities are lined with mesenchymal elements, and cavities due to inflammatory and non-inflammatory (vascular) softenings. Obviously, many so-called syringomyelias have for their immediate cause one of these factors, although Schlesinger and others question whether a gliosis or a glial deficiency is not the primary cause.

That true syringomyelia is dependent on or associated with congential anomalies in the central nervous system is suggested by the following facts: (1) It is a disease whose onset occurs in early life, the average age being under 30 years. (2) Associated with the cavity formation, and often more conspicuous and extensive, is a gliosis. This gliosis may be pictured as a benign hyperplasia of the glial cells which does not take on the proportions of a true neoplasm or glioma, but which yet constitutes a destructive agent to nerve tissue. Schultze in 1882 first clearly stated this view and compared a gliosis to a glioma as a fibroma to a sarcoma. (3) At the advancing ends of a cavity or in the walls of a newly-forming cavity the astrocytes are much more conspicuous and immature, indicating that glial hyperplasia may be the forerunner of the cavity. Cases occur in the literature in which gliosis is the principal lesion. (4) The chief site of occurrence of gliosis and cavity formation is in the posterior grey matter of the cord, either in the central grey matter lateral to the central canal, or in the root of the grey horn, or in one or the other of the posterior grey horns. These are the sites in which most frequently occur embryonic rests of ependymal cells. Case 1 of our study shows groups of ependymal cells scattered into the horns lateral to the canal.

In the fetal cord of a six-weeks' embryo, the form of the lumen of the neural canal becomes "further modified by the elongation and narrowing of the dorsal part of the canal in consequence

of the approximation of its walls, which by the end of the second month, is completed by the meeting and fusion of the adjacent inner layers with obliteration of the intervening cleft" (Piersol[1]) . . . "As the walls come together the cells lose their radial direction and form a unilateral compact strand which is soon replaced by a sparsely nucleated seam of supporting tissue. It is the extension of this seam of closure that eventually forms the posterior median septum" (Keibel and Mall[2]) Failure of a part of these ependymal cells to form mature neuroglial cells of the septum or a similar failure of the lateral horns of the canal to close normally may result in the presence of anomalous rests of cells in the posterior grey commissure or in the roots of the grey matter. Bielschowsky is further of the opinion that the disease may arise from interference with the development and typical differentiation of the spongioblasts in the lateral wall of the tube. These spongioblasts, which normally would produce adult neuroglial supporting cells for the gray matter, may undergo metaplasia and produce a spongioblastosis or gliosis. Spiller[3] also mentions a frequent point of attack in syringobulbia with ependymal-lined cavities and fissure formation to be the anterior portion of the posterior limb of the internal capsule which marks the line of coalescence between the corpus striatum and the thalamus.

It is plausible then to consider that such nests of ependymal cells may under appropriate stimuli undergo some degree of hyperplasia sometimes amounting only to a gliosis, sometimes to a true gliomatosis.

That arrested development of ependymal cells may lead to a glial proliferation and later to cavity formation is held by a large number of workers, among them Schultze (1882), Shlesinger (1894), Oppenheim, Unger and Bielschowsky, Bremer, Ostertag, and Marinesco and Draganesco. Unger and Bielschowsky have stated that "in post-fetal life, acquired syringomyelia and gliosis are not present" and that syringomyelia is in fact a *spongioblastosis* due to an existing dysraphia. These authors even declare that hydromyelia, in which there is a condition of the central canal resembling the embryonic state, is transmutable into syringomyelia since both are phases of the same anomalous condition. J. K. Hoffman[4] (1931) also holds the theory of primary gliosis and explains the cavity formation as due to edema from circulatory disturbances and subsequent transudation into the center with splitting. Since he considers that gliosis and gliomatosis are related in degree he is committed to the view that syringomyelia associated with gliosis and syringomyelia associated with gliomatosis are aspects of the same anomalous condition. Ribbert, Woods,[5] and Klotz[6] hold this view. The frequent association with syringomyelia of other anomalies is in favor of the congenital theory. Schlesinger states that such exist in one-third of the cases. Bassoe[7] mentions the frequent association of cervical ribs with the disease, and Morris[8] explains this on the basis of the close relation of the neural tube and the bone-forming mesenchyme in the cervical region of the early embryo. Other coincident anomalies are spina bifidia, scoliosis, defect of the pinna, arraphia, web-fingers and toes, and talipes. (7) Evidence of the association of intramedullary tumors and syringo-myelia which is too authenthentic to be disregarded.

Penfield[9] states that in his series of nine cases of primary intramedullary tumors of the spinal cord there was a coexisting syringomyelia in five. The tumor types included two ependymomas, one medulloblastoma, one oligodendroglioma, and one hemangioma. Furthermore in his series of twelve cases of syringomyelia, five were associated with primary tumors of the cord. From the literature we gathered eight cases associated with medullary gliomas verified anatomically. (Klotz[6], Lloyd[10], a possible one of Merrill's[11], Woods[5], three of Hoffman's[4], Gunn[12].) To these we add the four of Penfield's series. These may not be impressive figures, but they do not represent all recorded cases. (8) That the process leading to syringomyelia may be a neoplastic one is suggested by the good results obtained by roentgenotherapy reported in the literature by a number of authors. Delhern and Morel-Kahn[13] reported 150 cases from the French literature which were improved by this treatment, or about 70 per cent of the cases reported since 1905. In their own series of sixteen, they had less favorable results, but felt justified in concluding that in cases where the neoplastic process is not far advanced, good results may be obtained. They warn that the field of irradiation should include a larger area than that indicated to be involved by neurological examination.

Of the theory that syringomyelia is a degenerative process, Hassin[14] (1920) and Tannenberg are the chief supporters. Kirch and Tannenberg held that gliosis is the result rather than the cause of cavitation, that cavity formation is the result of degeneration from circulatory disturbances in the end arteries and that the gliosis is part of the healing process. Hassin holds that in true syringomyelia a glial deficiency—a true abiotrophy—leads to degeneration; the necrotic glial tissue acts then as a foreign body in producing encapsulation by connective-tissue invasion from the meninges. In his case he finds support for this view. We, however, although employing the same and other differential stains on material in our cases, could find no evidence that connective tissue ever lines the cavities or that it was increased, save in the adventitia of the regional blood vessels and in the pia-arachnoid. Neither in our cases did we find any evidence of necrotic material in the cavities such as one would expect to

find if the disease were a degenerative one. The fluid which escapes on opening the cord in these cases is clear. Furthermore, the shape of the fissure-formations suggests that which would result from splitting rather than from degeneration.

From a survey of the literature and from a study of our cases we are impressed by the very frequent occurrence of the cavities at points where unusual strain may be brought to bear on the tissues.

We have already mentioned Spiller's suggestion of the frequency of splitting at the opto-striate notch, a region of incomplete fusion. In the medulla the site for fissure formation closely coincides with the zone occupied by the sulcus limitans in the embryo. This notch which is marked in the early human embryo is lined with ependymal cells and in this region might conceivably be left rests of ependymal cells. Here is likewise a zone of maximum strain due to the tension from the large developing restiform body and rhombic lip on the one side and the large olivary eminence and pyramidal tract on the other. We suggest that these two factors, (1) weakened resistance through glial hyperplasia from ependymal rests and (2) increasing strain as explaining the usual site of fissure formation in the medulla.

In the posterior horns of the cord which have not hypertrophied as have the anterior horns, we have also an area under stress from the large lateral and anterior white columns and the columns of Goll and Burdach, all especially hypertrophied in the upper levels of the cord. At the cervical and lumbar enlargements the larger anterior horns exert tension on the roots of the central grey matter. The posterior grey horn may then be conceived of as the line of weakest resistance in the cord, and if this point is further weakened by a region arrested development in the neuroglial supporting tissue and its hyperplasia resulting in abnormal lines of stress, it is plausible to think that fissure formation might result. This "splitting" process may be further aided by the edema of disturbed vascularity, transudation, and subsequent "tracking" laterally and up and down the cord.

The existing glial cells, both of the hyperplastic area and the surrounding nerve tissue, tend to set up a reactionary reparative process, and it is this attempt at healing that is present about the cavities in different stages of maturity. It is therefore a secondary glial reaction. Connective-tissue elements in the blood vessels tend to undergo hyperplasia and hyalinization from tension and the vascularity to increase in amount. The thickness and vascularity of the wall depends on the age and progressiveness of the lesion. In the medulla, pons, and upper cervical cord of Case 1 the tissue was young and gave evidence of growth and recent origin; in the lumbar region the process was fairly stationary, suggesting that in this case the condition had existed in the cord for a long time and had become exacerbated some months before death with expansion of the thoracico-cervical region and extension into the medulla and pons. Prior to this, the destruction of grey matter had not been sufficient to cause serious symptoms.

SUMMARY

1. Syringomyelia is a congenital disease of the glial tissue resulting from fetal malformations in the closure of the neural canal.

2. Glial hyperplasias and sometimes gliomatosis originating in embryonal rests of ependymal cells are the forerunners of cavity formation in true syringomyelia.

3. Cavity formation generally originates in zones of greatest stress in the grey matter.

4. One case is reported with scattered ependymal rests in the central grey matter of the cord and cavity formation in the cord, medulla, and pons which probably originated in the right posterior grey horn of the cord and recently underwent distention in the cervico-thoracic region and extension into the medulla and pons with involvement of nuclei and tracts concerned with swallowing, phonation, respiration, pulse regulation, oculmotor movements, and the coordination of movements of the extremities. Taste on the posterior portion of the tongue and deep-joint sensibility were abolished.

5. Theories of the cause of syringomyelia as discussed in the literature are reviewed.

6. It is held that the presence of congenital glial hyperplasia in zones of maximum strain in the developing nervous system accounts for the majority of cases of true syringomyelia. Disturbed circulation, edema and transudation into the forming cavity and subsequent "tracking" are factors in the completion of the process.

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THE HYPERMATURE CATARACT, ITS PROGNOSIS AND TREATMENT

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WHILE it is probably true that ophthalmologists are seeing fewer hypermature cataracts in their daily practices, and this is particularly true of the Morgagnian type, the problems presented by the extraction of these cataracts may offer certain difficulties. In addition, the pre-operative and post-operative complications may be serious and even fatal to vision. Also there is a common belief, held especially by ophthalmologists who have not done a great deal of cataract surgery and consequently have not had much to do with the hypermature cataract, that a cataract should not be removed, no matter what its developmental stage may be, so long as the other eye has good vision. Certain facts have recently been determined by modern biochemical studies of lens changes which throw a new light on the subject. For these reasons it seems to me pertinent to discuss this question, hackneyed as it may appear to be at first glance.

It is not within the scope of this paper to go into details on how the hypermature stage is reached. One can readily believe that it is but a step in nature's method of removing or clearing up a bodily structure whose function has been lost. H. Gifford has said that while it is probably true that everyone would develop a senile cataract if he lived long enough, so also would everyone obtain a spontaneous cure, if life were sufficiently prolonged.

The mature senile cataract evolves into several forms.

(a) The shrunken, hard, disc-like cataract occurs chiefly in patients over 70 years of age or in those who have deferred operation years after the maturing of a perinuclear cataract. It seems to be all nucleus, since at operation all of the fibers of the lens—cortical and nuclear—adhere intimately and the cataract shells out leaving perfectly clean capsules. This form of hypermature cataract belongs to the class that is removable by any form of operation and in the hands of any operator. To this class, also, belongs brown cataract, so often called black. The hard cataract offers the best opportunity for delivery in the capsule by the forceps method, since the capsule is generally thick and not fragile, because it is not stretched, and the suspensory ligaments are reasonably weak, as Smith says, the degree depending solely on the age of the patient. The ordinary cystotome operation is not advised because of the thick capsular and often calcareous after-cataract which frequently follows. These hard cataracts may become partially dislocated, and while this is apparently rare, when they do, it is a difficult job to remove them, especially in the presence of glaucoma. Miotics, a preliminary iridectomy, followed by delivery on a spoon with Smith pressure, have worked best in my hands.

(b) The second type, the Morgagnian cataract, is the more common, and forms the chief topic of discussion in this article. R. H. Elliot noted that 17 per cent of all cataract cases in Madras, India,

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were Morgagnian. Salus believes that the cataract matures more quickly in hot countries. In the Morgagnian cataract the nucleus is small throughout, but the cortex, by autolysis, rapidly liquifies, absorbs moisture, as shown by S. R. Gifford, and becomes swollen. Its tumescence is revealed by the increase in its anterior posterior diameter, the shallowing of the anterior chamber, its pearly or soapy appearance, and the tense thin capsule which, on being opened, literally explodes its milky contents.

Should the evolution continue into what Colonel Smith calls the "hypermature Morgagnian cataract", the fluid contents absorb, the anterior and posterior capsular walls become shrunken and thrown into folds, a rudiment of the nucleus perhaps still in the lower portion, and the lens dislocates, either before or after this stage, into the vitreous where even the nucleus and the capsule may be more or less completely absorbed (Jess). Or the nucleus may share in the autolysis of the cortex and disappear within the capsule, which now contains nothing but debris, cholesterin crystals, leucin, and other products of distintegration (Taylor, R. H. Elliot). Spontaneous absorption of a Morgagnian cataract is apparently not rare according to case reports. Von Reuss collected thirty-four such cases. Others have been reported by Weill, Gifford, Verrey and Mitwalsky. Spontaneous intraocular rupture of the Morgagnian cataract has been known to occur. Cases are described by Szily, von Ulrich, Arlt, Kaufmann, Gonzales, Shahan, and Rollet and Genet.

Before modern biochemical methods were evolved it had been noted by astute observers like H. Knapp, H. Gifford, Collins, and Coats that a Morgagnian cataract sometimes produced intraocular inflammation. They attributed this to chemical changes going on within the capsule producing a toxin which was absorbed through the capsule wall. Other investigators, among them Linder, found that iritis secondary to cataract extraction, even when hypopyon is present, is not always bacteriologic. Verhoeff and Lemoine developed a theory of anaphylaxis due to lens debris following cataract extraction in a sensitized individual. Rőtth, in a recent important work, found that lens cortical substance injected into the anterior chamber of a rabbit produced little irritation there. It was not the same, however, with nuclear fragments which produced a fibrinous iritis. Alpha and Beta crystalline scarcely produced irritation, and a fragment of nucleus was found to be more irritating than the entire nucleus. H. Gifford had found this clinically true and relates (1918) of a case where there was a hard nucleus in the anterior chamber. There were periodic attacks of intense pain, iritis, congestion and glaucoma, with absence of trouble in the interim. He attributed this phenomenon to the sudden breaking down of the outer shell of the nucleus, which, in the quiet periods, was slowly preparing for the change. R tth found that if lens proteins are dissolved in trypsin one obtains, by the products of disintegration, an iritis the intensity of which is in relationship with the concentration of the inoculated products. Peptone produces a particularly active irritation. Among the amino acids, a quantity which one can obtain by digesting half a cataract, arginine and insoluble cysteine provoke a violent reaction, as minimal as the quantities introduced. R tth thus believes that due to autolysis and hydrolysis in the hypermature cataract, tyrosin, cysteine and possibly also higher products of dsintegration develop, which are toxic to the iris. He also thinks that diffusion of toxic products exists through the capsule, a view hesitantly supported by S. Gifford, but concurred in by Verhoeff, H. Gifford, Kretz and others.

Gabrielides and others found crystal-like bodies in the nucleus of Morgagnian cataracts. Coats identified these as leucin. They were never found in the cortical débris, but isolated in the nucleus, and he cites Becker (1877), Baas (1867), Axenfeld (1900), and Hess (1905) as making similar observations.

A. Knapp and Feingold believe, however, that the displaced nucleus must cause some mechanical irritation of the ciliary processes and thus lead to inflammation and its sequellae. Knapp's two cases, which he cites in support of his view, on close analysis appear to contradict his ideas. His first case, in which the nucleus of a Morgagnian cataract was left behind, resulted in secondary uveitis and glaucoma. It is additional evidence to support Rőtth's theory. His recent case, where glaucoma disappeared on removal of a Morgagnian cataract, had been preceded by a low-grade chronic uveitis, which H. Gifford believes is supporting his toxic theory.

The weight of clinical and experimental evidence therefore points towards the toxic rather than mechanical theory as a cause of iritis and glaucoma in these cases. The role of the nucleus, especially, in causing the irritation, seems to be well demonstrated. H. Gifford, that shrewd clinician, said in 1927, "It seems much more likely that the symptoms were due to the slow absorption of nuclear substance, rather than to any mechanical effect".

The complications of hypermature Morgagnian cataract are:

(a) *Subluxation, or luxation of the lens.*

The latter may be into the vitreous, or into the anterior chamber and produces iritis and glaucoma.

(b) *Glaucoma.*

This may occur as a result of toxic absorption and uveitis, or by irritation by mechanical pressure, of a luxated lens.

Before luxation, however, glaucoma may ensue (1) as a result of shallowing of the anterior chamber and blockage of the angle (Smith); or

(2) following a low-grade uveitis as a result of absorption of toxic products (Gifford, Verrey), as was already pointed out; or (3) resulting from blockage of the anterior chamber by broken-down lens débris from a spontaneous, partially ruptured capsule(Kaufmann).

(c) *Uveitis.*

This may follow toxic waste products or mechanical pressure exerted by a luxated lens only, as has been demonstrated earlier in the article. Choroiditis has also been observed (Thomson) as a complication of Morgagnian cataract.

The treatment of the hypermature cataract has already been discussed insofar as the hard type is concerned. The Morgagnian type offers certain other problems.

1st. Before complications, especially glaucoma, have developed. It must be remembered that the cataract is swollen, baggy and large. Therefore a large incision must be made. The capsule is fragile, the cortical-fluid toxic, and the ligament fibres easily ruptured. Thus care and delicacy must be used to avoid opening or rupturing the capsule. The cataract is easily dislocated by pressure, or as Colonel Smith says "by an angry look", and is ideally suited for the Smith-Indian operation. Capsulotomy results in violent explosive opening of the capsule with extrusion of its contents and has been followed by iritis, updrawn pupil, and even loss of the eye, as a study of case reports show. Capsule forceps are applied with much difficulty to the slippery, slimy, tense, fragile capsule, with the frequent rupture and sequellae. Hence the Smith-Indian operation offers the safest and actually the easiest way out. It should be pointed out, however, that should the capsule rupture before delivery in any of the preceding methods, the anterior chamber is usually quickly evacuated of the milky contents. If not completely so by nature, then one can, and always should, irrigate the anterior chamber, even if it appears to be free of debris. The small, hard nucleus may become "lost" and later lead to trouble (Knapp's case). A point to bear in mind is, that due to the shallow chamber, the iris is apt to be cut by the knife in making an incision. It is easy, however, to make a small incision and enlarge it with curved scissors, right and left, fully 180 degrees of the circle.

The Smith-Indian operation has been described so many times, that it needs no further discussion here. The interested reader, however, will find it adequately detailed in Ball's Modern Ophthalmology. One should always try to deliver the lens as a "tumbler" since that appears to be the easiest and safest way.

The authorities who favor the intracapsular method as the one of choice are several; among them are Smith, Elschnig, Verhoeff, Peter, DeSchweinitz and Knapp.

2nd. After glaucoma has resulted, however, opinion differs about the proper procedure. Since the lens is the cause of glaucoma (whether toxic or mechanical) it must be removed, before the danger of subsequent attacks is eradicated.

All writers on the subject agree that miotics should be given a trial before the cataract is removed. That they are not always successful is shown by Salus. Cyclodialysis is advised by Elsching and Peter. Posterior sclerotomy is the method of choice, according to Salus, who tried other procedures with varying success. He particularly condemns the preliminary iridectomy because of the danger of prolapsed iris.

While the experience obtained in two cases does not permit one to be dogmatic, still I should like to go on record as being in favor of proceeding with the intracapsular cataract extraction, even in the presence of higher intraocular tension.

The following two cases are illustrative:

Case 1. Dentist, 78. O. D. cataract removed 1916 (intracapsular) by D. T. Vail, Sr., vision 20/20. Was seen on October 15, 1929, complaining of severe pain and inflammation of O. S. of 10 days duration. Had known since 1914 that he had a cataract in this eye, and that it had been mature for at least 10 years. In 1925 it was found to be hypermature and its removal advised.

Examination (1929) showed a hypermature tumescent cataract and usual signs of acute glaucoma, except that the anterior chamber was not shallow, and the plane of the iris was flat, indicating partial subluxation, although no iridodonesis was observed. Pupil was inactive. Tension 45 mm. (Schlotz). Light projection was good. Corneal epithelium was bedewed, but no punctate deposits of the posterior surface were seen with the slit lamp and biomicroscope. Cataract extraction was advised. The patient's vascular system was serously diseased. Coronary thrombosis in 1925. Blood pressure was 170/65 and there was marked retinal ateriosclerosis as observed in the right eye.

Miotics were used repeatedly for 24 hours without reducing the tension. Under cocaine anesthesia, lid akinesia and subconjunctival injection of 2 per cent procaine, the operation was done. A Verhoeff suture was inserted, small Graefe knife incision made, and enlarged with scissors; iridectomy. A large, baggy, Morgagnian cataract was delivered as a tumbler by Smith pressure. There was no loss of vitreous. Healing was uneventful. There was no recurrence of glaucoma. Vision two months later with correction was 20/30 and J. No. 1. The vitreous showed a few floating opacities.

Case 2. Grocer, 43. Seen October 17, 1933. History: cataract left eye for 18 months. Had had no ocular symptoms until six years before when vision O. S. became hazy for three or four months, but this cleared up until about 18 months ago, when vision gradually failed. There was no pain or inflammation. Had had a previous diagnosis of uveitis and secondary cataract made. Complete physical examination was negative except for several abscessed teeth, which were removed at the onset of his difficulty.

Examination: O. D. entirely normal. O. S. Cornea clear, eyeball was free of congestion. There was normal light projection. The anterior chamber was very shallow, iris somewhat "mossy", hypermature, mother of pearl cataract present. Tension 38 mm. (Schiötz).

Biomicroscopy showed few old deposits on Des-

cemet's membrane, patchy atrophy of iris stroma; gelatinous atrophy of the iris pigment at pupil margin. There were no Koeppe nodules.

One per cent pilocarpine was instilled and the patient directed to use it four times daily and return frequently for observation. He was warned about an acute attack of glaucoma. Sixteen hours later he was in the hospital with an acute attack of glaucoma which required morphine for the pain. Glaucosan was used, but the tension remained 38 mm. (Schiötz). It was undoubtedly precipitated by the miotic, in the presence of uveitis. An immediate operation, exactly similar to Case 1, was performed with no complications and uneventful healing. Many large floating vitreous opacities were seen. A "cotton spot" in the choroid was seen in the floor and temporal side. It was pigmented. Vision six months later was 20/50.

Since the glaucoma is not primary, there does not seem to be any risk of an expulsive hemorrhage in these cases (Smith). This is borne out by the experience of Case 1. A worse risk, from a vascular standpoint, could scarcely be imagined.

CONCLUSIONS

1. The mature cataract evolves into two types of hypermature cataract (a) the hard, disc-like form, (b) the Morgagnian form, which in its evolution becomes hypermature.

2. Clinical and experimental evidence leads one to believe that the Morgagnian nucleus is highly toxic, especially if it is broken into fragments.

3. Toxic absorption through the intact or broken capsule may result in uveitis and glaucoma.

4. The mechanical pressure of an intumescent cataract on the iris, blocking the angle, results in glaucoma sooner or later.

5. Intracapsular extraction appears to be the method of choice in removal of a hypermature cataract. The Smith-Indian method is favored.

6. After glaucoma has developed, an attempt should be made to reduce the tension before operation.

7 Intracapsular extraction (Smith operation) has been done successfully even in the presence of high intraocular tension.

8. It appears better to remove the mature cataract before it becomes over-ripe.

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—O S M J—

The Council on Community Relations of the American Hospital Association has suggested to Federal officials in an official communication that: (1) No new veterans hospitals should be built or existing ones expanded as long as there are unoccupied beds available in nongovernmental hospitals which could be used for the care of veterans; (2) no new public hospitals be built with P.W.A. funds until competent study reveals a real need for them; (3) no additions be provided in nongovernmental hospitals from P.W.A. funds without careful consideration and community planning.

—O S M J—

A proposal that the American Hospital Association and various state hospital associations adopt a plan of placing membership on a strictly institutional basis so far as possible, with representation based on bed capacity of the institution, was presented at a recent regional meeting in Chicago of hospital association officers by B. W. Stewart, Youngstown, president of the Ohio Hospital Association. The question was taken under consideration by officials of the national organization.

A CLINICAL STUDY OF GASTRO-ENTERITIS WITH SPECIAL REFERENCE TO THE CONTINUOUS INTRAVENOUS METHOD OF TREATMENT

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CINCINNATI, OHIO

THE death rates of infants with diarrhea or gastro-enteritis have been steadily declining during the last two or three decades. In Cincinnati, this reduction in mortality has been very evident, but the decrease has been slower than in other cities of the same relative population and geographic location. In order to compare certain local conditions with those of other cities a clinical study has been made of the patients with this disease who were admitted to the wards of the Cincinnati General Hospital during the past ten years from 1923 to 1932, inclusive. Special emphasis has been placed on the relationship of the incidence of the disease to climatic conditions, to types of feeding, to other infections and finally to the methods of treatment. There is also included a preliminary report on the results of the continuous intravenous method of therapy.

Mortality Rates. In Cincinnati, the number of infants under two years of age who have died of gastro-enteritis has fluctuated considerably during the past ten years. The greatest number, 174, occurred in 1926 and less than one-third as many, 52, in 1932. The figures are as follows:

Chart No. 1

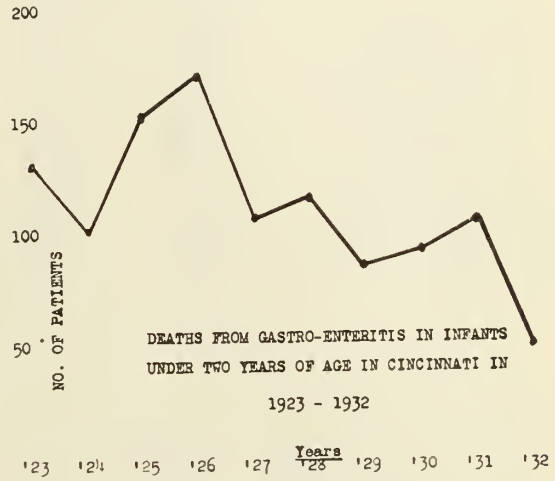


TABLE I

NUMBER OF GASTRO-ENTERITIS DEATHS IN INFANTS UNDER TWO YEARS OF AGE IN CINCINNATI

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Black	White	Total
1923	9	1	8	5	7	6	11	41	21	16	3	6	17	117	134
1924	1	3	4	5	2	4	12	30	13	9	8	12	11	92	103
1925	5	1	4	3	3	6	31	37	32	20	6	7	20	135	155
1926	8	5	4	5	6	4	22	44	37	29	4	6	20	154	174
1927	2	2	5	4	4	3	15	21	27	11	7	8	19	90	109
1928	10	2	3	3	4	1	5	29	36	9	9	8	17	102	119
1929	7	4	2	6	1	5	13	14	18	16	2	1	16	73	89
1930	8	3	1	1	5	2	4	18	25	18	8	2	16	79	95
1931	3	0	4	3	1	3	10	26	24	19	9	7	27	82	109
1932	0	6	2	5	1	6	12	12	1	5	0	2	....	....	52
Total	53	27	37	40	34	40	135	272	234	152	53	59	163	924	1139

In a recent investigation made by the Public Health Federation of Cincinnati, the infant mortality rates in this city over a period of three years, 1929, 1930 and 1931, were compared with those of twelve other large cities located in the same general area. In these statistics, deaths of transient families were excluded. The lowest death rates for white infants occurred in Cleveland and in St. Louis, and the highest in Cincinnati. In the accompanying table (II) these cities are arranged in order of increasing mortality rates for white and negro infants separately.

Age and Race Distribution. It is well known that gastro-enteritis is more common and more severe in younger infants and consequently the mortality is higher in that age group. Deaths were about twice as numerous in the negro as in white infants. Cities with a large negro population are, therefore, apt to have higher total death rates from gastro-enteritis. A tabulation of the average mortality rates for a three-year period in thirteen large cities is given below (Table III) in age and race distribution. The data for Cincin-

Read before the Section on Obstetrics and Pediatrics, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7 and 8, 1933.

From the B. K. Rachford Department of Pediatrics, University of Cincinnati, and the Children's Hospital and Research Foundation, Cincinnati.

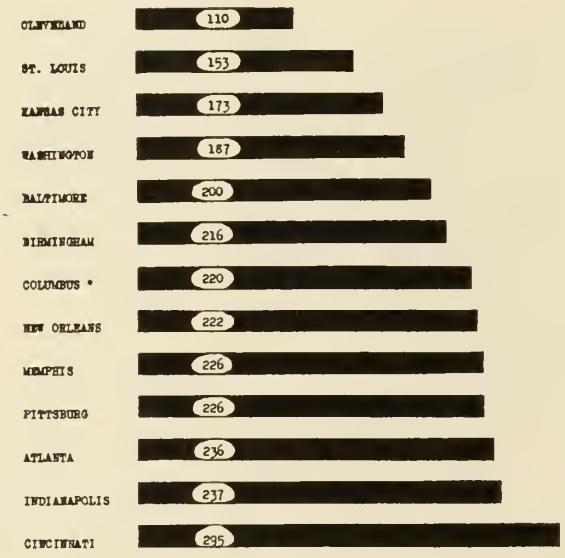
TABLE II

MORTALITY RATES OF GASTRO-ENTERITIS IN THIRTEEN CITIES IN 1929, 1930 AND 1931
(For Infants and Children Under 5 Years of Age)

	White			Negro		
	City	1930 Infant Pop.	Enteritis Mortality Rate Per 100,000	City	1930 Infant Pop.	Enteritis Mortality Rate Per 100,000
1.	Cleveland, O.	63,942	110.0	Cleveland, O.	6,458	227
2.	St. Louis, Mo.	51,672	153.0	*Columbus, O.	2,612	249
3.	Kansas City, Mo.	23,454	173.4	Pittsburgh, Pa.	4,934	250
4.	Washington, D. C.	22,240	187.4	Birmingham, Ala.	8,717	302
5.	Baltimore, Md.	52,146	200.7	Kansas City, Mo.	2,154	309
6.	Birmingham, Ala.	14,026	216.3	Memphis, Tenn.	7,062	316
7.	*Columbus, O.	19,521	220.0	Baltimore, Md.	12,274	320
8.	New Orleans, La.	26,961	222.5	St. Louis, Mo.	6,634	367
9.	Memphis, Tenn.	12,649	226.0	Indianapolis, Ind.	3,457	463
10.	Pittsburgh, Pa.	52,120	226.0	Washington, D.C.	10,006	489
11.	Atlanta, Ga.	13,835	236.0	Atlanta, Ga.	7,090	522
12.	Indianapolis, Ind.	24,183	237.0	Cincinnati, O.	4,003	525
13.	Cincinnati, O.	29,389	295.0	New Orleans, La.	11,518	547
	Totals	406,138	191.6		86,919	387

NOTE: *Based on two-year statistics (1930, 1931). Separate figures of white and negro population for 1929 not available.

CHART No. 2
MORTALITY RATES OF GASTRO-ENTERITIS IN THIRTEEN CITIES IN 1929, 1930 AND 1931



* NOTE: Based on 2 year statistics (1930 and 1931) only.

nati are given in a separate column and they show higher rates in all age groups and in both white and negro races.

HOSPITAL PATIENTS WITH GASTRO-ENTERITIS

Age Incidence and Mortality. During a ten-year period from 1923 to 1932 inclusive, 821 infants and children were admitted to the Pediatric Wards of the Cincinnati General Hospital with the complaint of gastro-enteritis. Approximately half of this number, 400, or 48.7 per cent were under seven months of age, 188 or 22.9 per cent were seven to twelve months of age and 233, or 28.4 per cent were older than one year. These patients represented the lower social and economic levels of the community. Only children with the most severe infections were admitted to the hospital and, therefore, the mortality rates among this group were high. Of the infants six months of age or younger, 175 or 43.7 per cent died, of those seven to twelve months of age 67 or 35.6 per cent died, and of those over a year of age, only 24 or 10.3 per cent died.

TABLE III

INFANT MORTALITY FROM GASTRO-ENTERITIS IN 13 LARGE CITIES IN 1929, 1930, 1931

	White		Negro	
Age	Enteritis Mortality Rate Per 100,000	Comparative Cincinnati Mortality Rate Per 100,000	Enteritis Mortality Rate Per 100,000	Comparative Cincinnati Mortality Rate Per 100,000
Under 1 Yr.	755.0	1175.0	1589.0	2390.0
1 Yr.	176.0	225.0	349.0	320.0
2 Yrs.	44.0	73.0	69.0	80.0
3 Yrs.	19.6	34.0	39.3	38.0
4 Yrs.	9.5	11.5	14.7	0.0
Total	191.6	295.0	387.0	525.0

TABLE IV

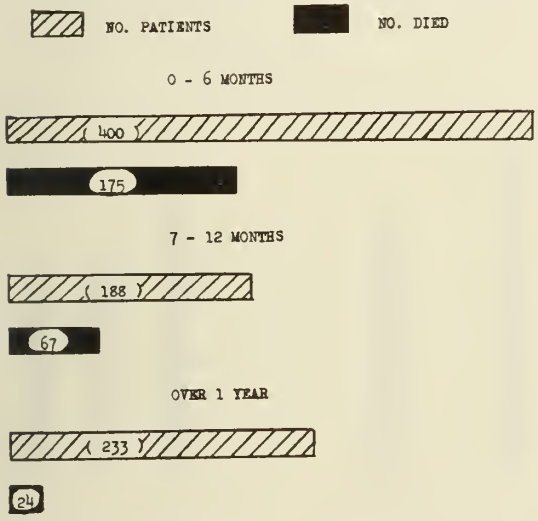
MORTALITY RATES OF 821 CHILDREN WITH GASTRO-ENTERITIS ADMITTED TO THE CINCINNATI GENERAL HOSPITAL DURING THE YEARS 1923-1932

Age Group	Total No.	Mortality	Percentage
0 - 6 Months	400	175	43.7
7 - 12 Months	188	67	35.6
Over 12 Months	233	24	10.3
Total	821	266	32.4

Seasonal Fluctuation. The influence of warm, humid climate on the incidence of gastro-enteritis has been noted for many years. Some clinicians, however, have claimed that in recent years the seasonal variation of the incidence of enteritis has diminished and that the number of cases is about

CHART No. 3

ENTERITIS MORTALITY IN THREE AGE GROUPS CINCINNATI GENERAL HOSPITAL, 1923-1932



equally distributed between the summer and winter months. Gastro-enteritis was observed on our wards during the winter months, but it was usually of short duration and was either associated with severe infections of some other type or was the terminal symptom of a fatal illness. These patients rarely developed the severe, protracted diarrhea with marked dehydration. In our series, the number of patients with enteritis admitted to the wards has increased during or immediately after an average elevation of temperature above 85° F. for a week or more (see chart No. 4). Occasional exceptions have occurred in that a relatively hot month has been accompanied by fewer cases of enteritis than a preceding or subsequent cooler month. In the charts Nos. 5, 6 and 7, a comparison is made between average weekly maximum temperatures and the number of enteritis patients admitted to the hospital each week. A correlation between the two seems to be more marked in some years than in others.

Parenteral Infections. Within the last seven or eight years, emphasis has been placed on the importance of parenteral infections, especially otitis media, as etiologic factors leading to gastro-enteritis. In our series of patients, infections of the

CHART No. 4

SEASON FLUCTUATION OF MORTALITY FROM GASTRO ENTERITIS SUMMARY OF 10 YEARS IN CINCINNATI

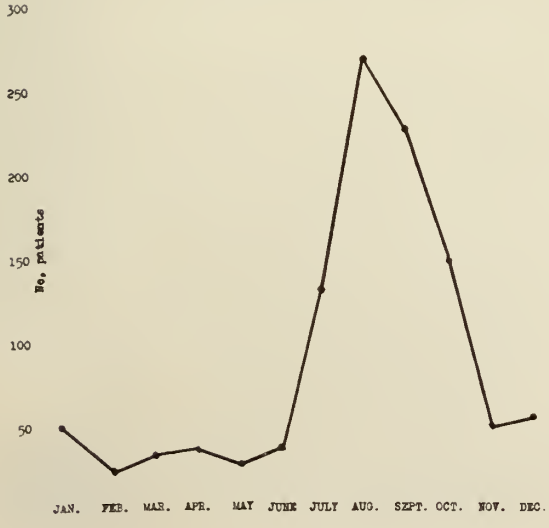
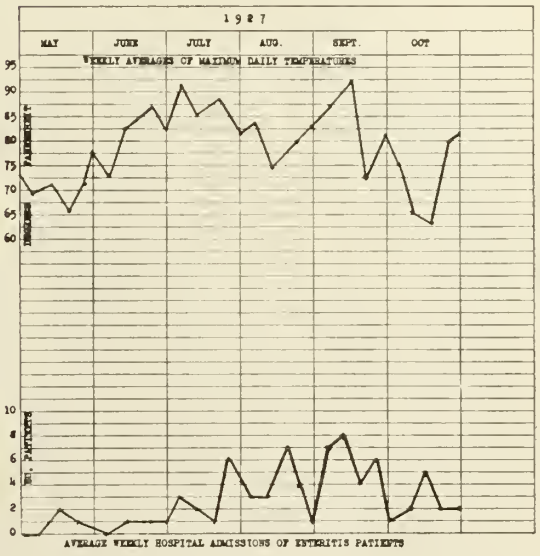


CHART No. 5



respiratory tract such as nasopharyngitis, bronchitis and bronchopneumonia together with otitis media, tonsillitis and furunculosis have been observed frequently in infants with gastro-enteritis. Among 683 infants with gastro-enteritis admitted to the hospital during the past eight years, 511 or 74.8 per cent had some one of these parenteral infections and of this group, 178 had otitis media only. The mortality rate was considerably higher in infants with such infections than in those with gastro-enteritis only. In 1929, for instance, of the total number of 31 infants who died, 26 or 84 per cent had parenteral infections, but of the 62 infants who recovered only 32, or 52 per cent, had parenteral infections.

Such infections were much more common among the infants under one year of age than in older patients. In a group of 393 infants with gastro-

CHART No. 6

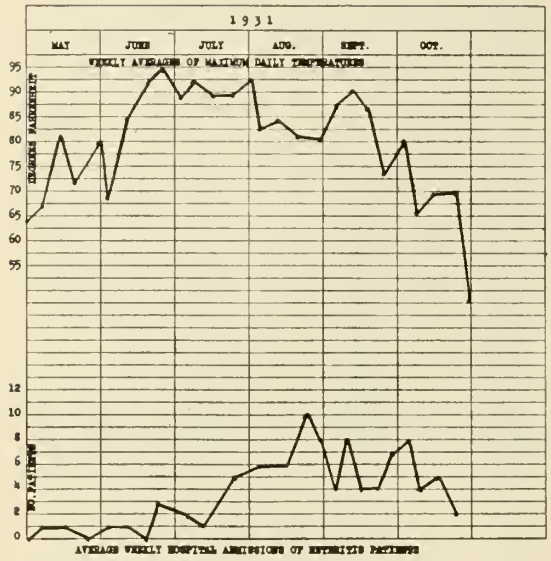
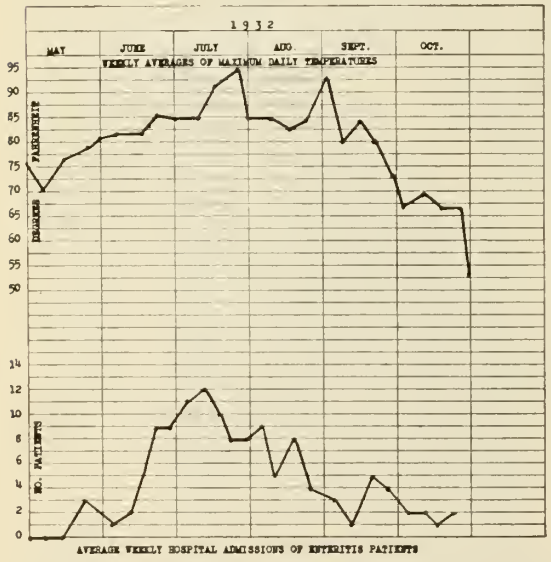


CHART No. 7

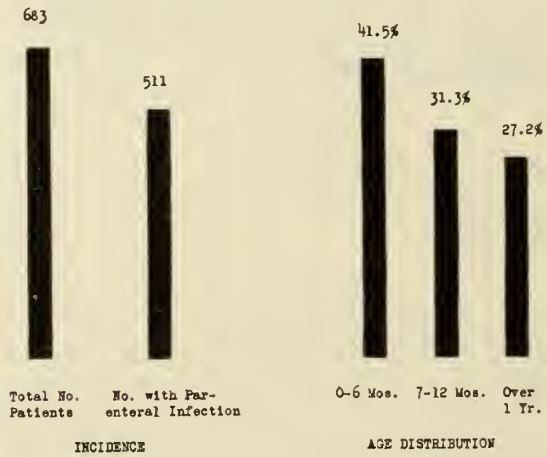


enteritis and a parenteral infection, 163, or 41.5 per cent, were less than seven months of age, 123 or 31.5 per cent were seven to twelve months old, and 107 or 27.2 per cent were over one year of age. (Chart No. 8.)

In a previous study of a group of 169 infants of the above series made by Mitchell and his co-workers,[1] no definite etiologic relationship between otitis media and enteritis could be established. The majority of infants with gastro-enteritis did not have preceding otitis media, while a great many infants with otitis media, especially in the cooler months of a year, did not subsequently develop diarrhea. Infants with both otitis media and gastro-enteritis were not materially helped by drainage of the middle ear or antrum, although such treatment was recommended whenever necessary.

For several years we were interested in noting whether the enteritis or some parenteral infection gave the first symptoms or clinical evidence of the illness. In a small group of 181 infants in whom there was sufficient lapse of time between the two lesions to determine which began first, 108 or 59.7 per cent had some evidence of infection preceding the gastro-enteritis. The remainder, 73 or 40.3 per cent had the gastro-enteritis as the initial symptom of disease and subsequently developed

CHART No. 8
PARENTERAL INFECTIONS IN GASTRO ENTERITIS PATIENTS



otitis media or some other parenteral infection. This was consistent with the observations made in the study just quoted. In a few instances, the parenteral infections may have been present some time before they were discovered clinically. For instance, a few small dehydrated infants were found to have pus in the middle ear although the drum did not appear to be red or bulging.

Bacteriology. A few infants each year had definite dysentery or typhoid fever infections, but these were not included in this series. During the last two years, Dr. Cooper has made special bacteriologic studies of the patients with gastro-enteritis (to be published later in the *American Journal of Diseases of Children*). He has demonstrated the presence of a pleomorphic streptococcus high in the intestinal tract of these infants, and early in the infection this organism could also be cultured from their nose and throat secretions. Animals injected with cultures of this streptococcus developed typical symptoms of enteritis and characteristic pathologic lesions of congestion, edema and ulceration of the intestinal mucosa. This organism occurred much more frequently in certain epidemics than in others.

Types of Feeding at the Onset of Diarrhea. The type of food which these patients were receiving at this time of the onset of the gastro-enteritis, varied considerably and the data collected have very little significance because of the lack of

knowledge of the diets of a control group who did not contract the disease. It was of some interest to note, however, in the group of 352 enteritis patients less than a year of age only 29, or 8 per cent, were breast-fed infants, while 187, or 53 per cent, had been receiving cow's milk formulas and the remainder, 136, or 39 per cent, had one of the proprietary foods, the most common being a sweetened condensed milk.

In the older infants and children food indiscretions frequently marked the onset of gastro-enteritis. Such foods were corn on the cob, green apples, new potatoes, plums, peanuts and string beans. Digestive disturbances of this kind occurring in the summer were usually much more severe and of longer duration than similar attacks in the winter months.

TREATMENT

The treatment of this group of 821 gastro-enteritis patients during the last ten years was based on the general principles of rest to the gastro-intestinal tract as long as possible and the administration of the necessary fluids and nourishment by all means possible.An infant was usually given nothing by mouth but water, with a small amount of added glucose or tea, for twelve to twenty-four hours. After this time the diet consisted of a small amount of milk from which the fat had been removed. It seemed to make very little difference whether this was skimmed milk, skimmed lactic acid milk or one of the proprietary protein milk mixtures. As the tolerance of the infant improved the quantity and concentrations of the mixture were increased and gradually the fat was placed back into the formula. In the meantime infusions of physiologic saline or 5 per cent glucose solutions were given frequently under the skin, intraperitoneally or intravenously to combat the dehydration. Blood transfusions were employed frequently. In spite of vigorous treatment of this sort, it was often difficult to overcome the dehydration or toxicity of the patient.

CONTINUOUS INTRAVENOUS THERAPY

In 1931, Karelitz and Schick[2] reported favorable results from the use of continuous intravenous drip in the treatment of toxicosis in infants. This method provides for a gradual administration of a large quantity of fluids, and has been employed successfully in adults for severe toxemia, loss of blood and other illnesses but technical difficulties had not made it practical for use in treating infants. Karelitz and Schick used a 5 per cent dextrose solution in physiologic saline or in Ringer's solution which they allowed to run in at the rate of 125 to 250 cc. the first 15 to 20 minutes, and 20 to 40 cc. per hour thereafter. From 345 to 4,900 cc. were given in this manner over a period of time ranging from 9 to 150 consecutive hours. Occasionally, blood or stimulants such as adrenalin and caffeine were added to the solution. The infants generally improved rapidly, vomiting ceased, weight increased, diarrhea was checked, kidney function improved, fluids were taken better by mouth and the signs of dehydration, acidosis and toxicity tended to disappear. By this therapy longer periods of rest for the intestinal tract were possible and the patient did not have to be disturbed so often. Among 30 severely toxic infants treated by this method, the mortality was 23 per cent, which was compared with a mortality rate of 46 to 64 per cent in previous years. In the following year, the same authors[3] reported that they had treated an additional 53 enteritis patients with the continuous intravenous method, and the mortality of this group was only 12 per cent as compared with 64 per cent of previous years. Following treatment, there was generally noted in these infants a rise in the CO_2 combining power of the blood, a diminution of the azotemia and a return of serum protein concentration to normal.

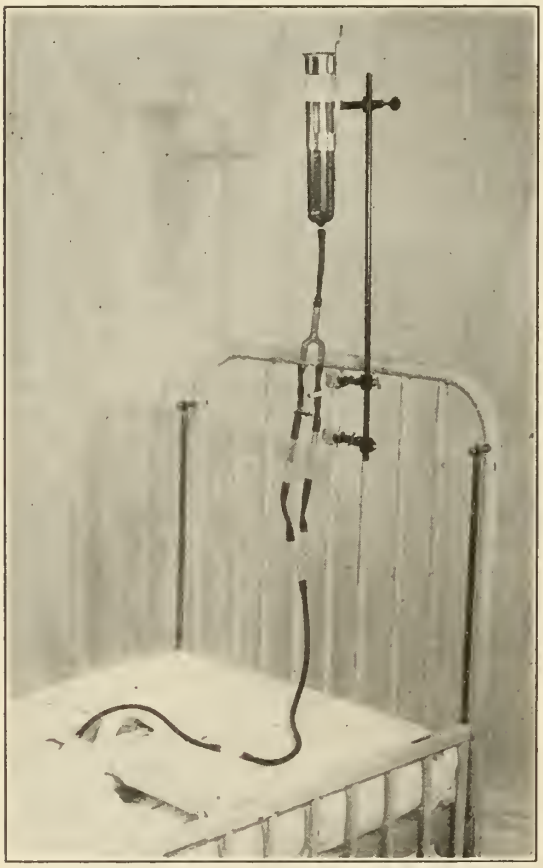
In 1932, Brush[4] made some changes in the apparatus which we have adopted since.

In a recent study of the effects of continuous intravenous therapy on the constituents of the blood of nine infants with intestinal intoxication, Cohen, Miller and Kramer[5] found that the procedure was very beneficial in combating dehydration and in promoting diuresis. Their patients, who were two months to two years of age, received by intravenous drip from 1300 to 2200 cc. of 5 per cent glucose in saline solution in a period of time ranging from 36 to 102 consecutive hours. Diuresis occurred usually in 10 hours or more, and this was followed by clinical improvement. The non-protein nitrogen, which was increased in amount in the majority of this group of patients, was restored to normal values by the treatment. In a few infants, the percentage of chloride binding base in the blood serum was low, but shortly after this therapy was instituted it also returned to normal. In three instances the treatment was followed by a generalized edema of the patient which was thought to be due to a rapid dilution of the serum proteins.

TECHNIQUE

We have followed the technique advised by the above authors. An incision, about one-half inch in length was made over the internal malleolus of the ankle to expose the great saphenous vein which lies very superficially. A cannula of as large a bore as possible was inserted and tied in place with catgut. At first, we employed cannulas made of various size needles which were cut off at right angles and the adges ground smooth, but later, on the recommendation of Brush,[4] ureteral catheters were used because they were more flexible and less apt to injure the vein. A sterile dressing was applied to the wound and the cannula was strapped to the infant's leg and connected with a long rubber tubing to a glass graduated container which was clamped to the bed. A Murphy drip bulb was placed about midway in

the rubber connection and the number of drops per minute was regulated by a clamp on the tubing. Occasionally an additional rubber tubing was constructed along the connecting apparatus with the aid of glass Y tubes. This facilitated cleansing of the system, eliminating the air, and the adjustment of the rate flow (see illustration). A two-way stop cock near the attachment of the needle would accomplish the same effect. The patient's leg was fastened to a small flat splint with adhesive and bandage. Various types of fluid were administered by this method. Usually a solution of 5 per cent glucose in physiologic saline was employed, but occasonally Hartman's or Ringer's solutions, blood serum and whole blood were used. The rate of flow was regulated by the dropper so that approximately 2 ounces of fluid per pound of body weight flowed in over a period of 24 hours.



Apparatus used for continuous intravenous therapy. (Note: A hot water bottle or electric pad is placed over the lower portion of the tubing to warm the fluid to body temperature.)

RESULTS

This method of giving fluid has been used in 17 infants with severe gastro-enteritis during the summers of 1932 and 1933. The ages of these patients ranged from seven weeks to five years. All were seriously ill and because of their toxicity, vomiting or convulsions, could not take fluids well by mouth. All but five had some parenteral infection such as bronchitis, pneumonia, otitis media, erysipelas or lead poisoning. Several patients were moribund and were not expected to survive more than a few hours so that the mortality rate of this group was high. Among those who survived, however, were several who had failed to respond to any other method of treatment and seemed to be greatly helped by receiving large quantities of fluid by the continuous intravenous method. In this group of patients, blood transfusions and medication were given as usual when necessary and there was no attempt made to secure a similar control group. This preliminary report is based only on the clinical response of the patients. (See Table V.)

No other method of treatment used previously has been as effective in combating dehydration as the continuous intravenous therapy. A much larger amount of fluid can be administered, and the assimilation is apparently much more rapid than by repeated subcutaneous or intraperitoneal infusions. The skin became more elastic and its color returned to normal. Circulation was improved and the infants were more alert.

Another striking result of this method of therapy was the increased tolerance of the infants for fluids given by mouth. Before treatment many of the patients either refused all fluids or persistently vomited even water or glucose solutions. After they received 500 to 1000 cc. of 5 per cent glucose in saline solution over a period of 20 to 24 hours they took quantities of fluid by mouth very eagerly.

Diarrhea was generally less severe after treatment, and in one or two instances, it ceased abruptly after a liter of fluid had been administered.

The therapy apparently had no beneficial effects on fever or on the other infections associated with gastro-enteritis. In fact, the group of patients with pneumonia were very little benefited by the treatment, and these infants constituted the majority of the fatalities which occurred in this series. Karelitz and Schick[2] also found the mortality among pneumonia patients high.

Precautions. The rate of flow of the solution must be watched carefully to make certain that the fluid is not flooding the circulatory system or that the flow has not ceased so that the needle or catheter becomes clogged and the blood clotted at its orifice.

Phlebitis developed in two of our patients and a diffuse swelling of the leg, perhaps associated with phlebitis, in two additional patients. The phlebitis was characterized by swelling, redness and tenderness along the course of vein extending into the femoral region. It occurred in patients who had had the needle inserted for 24 to 48 hours or longer. The condition subsided entirely when the venoclysis was discontinued and wet dressings were applied. Simple edema of the leg disappeared quickly when the treatment was stopped.

TABLE V

Patient	Age	Race	Symptoms on Admission	Intravenous Therapy Type	Amt.	Duration	Complications After Admissoin	Result
1. J.W.	2 yrs.	Negro	Diarrhea, nasopharyngitis, marked dehydration, vomiting	5% glucose in physiologic saline	400 cc.	6 hrs.	Lobar pneumonia	Died
2. E.S.	2 yrs.	"	Diarrhea, severe toxemia, nasopharyngitis, moderate dehydration	"	700 cc.	36 hrs.		Recovered
3. H.K.	3 mos.	White	Diarrhea, nasopharyngitis, otitis media, very toxic and dehydrated	"	600 cc.	30 hrs.	Erysipelas of face Bronchopneumonia	Died
4. J.L.	3 mos.	"	Diarrhea, vomiting, mild dehydration, otitis media	"	1250 cc.	32 hrs.	Edema of legs Pulmonary infarcts	Died
5. W.A.	7 mos.	Negro	Diarrhea, malnutrition, marked dehydration	"	1800 cc.	72 hrs.	Generalized edema	Recovered
6. J.W.	3 mos.	White	Diarrhea, otitis media	"	900 cc.	36 hrs.		Died
7. A.G.	5 yrs.	"	Diarrhea, vomiting, coma	"	1300 cc.	24 hrs.	Phlebitis	Recovered
8. M.E.	9 mos.	Nego	Diarrhea, marked dehydration and toxemia, otitis media, rickets	"	3100 cc.	108 hrs.		Recovered
9. R.J.	5 yrs.	"	Diarrhea, vomiting, convulsions, coma, lead poisoning	"	1400 cc.	30 hrs.		Recovered
10. A.J.	4 yrs.	"	Diarrhea, vomiting, convulsions, lead poisoning	"	650 cc.	6 hrs.		Died
11. N.S.	4 yrs.	White	Diarrhea, vomiting, nasopharyngitis	"	1800 cc.	56 hrs.		Recovered
12. J.W.	3 mos.	"	Diarrhea, malnutrition	"	1100 cc.	18 hrs.		Recovered
13. W.N.	1 yr.	"	Diarrhea, pharyngitis, bronchitis, otitis media, marked toxicity, vomiting	Hartman's solution	1850 cc. 1510 cc.	80 hrs. 45 hrs.	Mastoditis—operated Slight edema of leg	Died
14. E.G.	9 wks.	"	Diarrhea, pharyngitis, otitis media, marked dehydration	5% glucose "	1585 cc. 1200 cc.	48 hrs. 60 hrs.	Phlebitis	Recovered
15. R.M.	2 mos.	"	Diarrhea, severe dehydration, malnutrition	" Hartman's 5% glucose	975 cc. 1125 cc. 450 cc.	46 hrs. 57 hrs. 24 hrs.		Died
16. E.C.	7 wks.	"	Diarrhea, dehydration, pharyngitis	5% glucose	400 cc.	10 hrs.		Recovered
17. D.R.	2 mos.	"	Diarrhea, marasmus	5% glucose 10%	1125 cc. 1500 cc.	48 hrs. 48 hrs.	Edema of leg	Died

In one instance, the case of W. A., a generalized edema of the body developed after 1800 cc. of 5 per cent glucose in saline had flowed in over a period of 72 hours. This was apparently caused by dilution of the proteins of the blood. Chemical examination of his blood at the height of his edema showed:

Blood Constituents	Patient's Blood	Normal Value
Total protein	4.0	6.5-8.0
Albumin	2.66	4.5-6.0
Globulin	1.34	1.2-2.3
Calcium	6.5	10.0
Phosphorus	1.95	4.0
Chlorides	91.0	104.0

This condition gradually subsided and complete recovery followed.

In one infant in whom the flow of fluid was quite rapid for the first few hours there developed cyanosis and râles in the chest, a rapid heart rate and subsequently the patient died of pneumonia. Whether the continuous infusion overloaded his circulatory apparatus with resulting pulmonary congestion or infarcts is difficult to decide, but this must be borne in mind.

SUMMARY

1. In the general decline of mortality rates from diarrhea and gastro-enteritis during the last ten years, Cincinnati has lagged behind other cities of similar size and geographic distribution.

2. In this city, by far the greatest number of fatalities from the disease occur in infants under one year of age, and are about twice as numerous in the colored as in the white infants.

3. Among 821 infants and children with gastro-enteritis admitted to the Cincinnati General Hospital over the period of 10 years, from 1923 to 1932, 48.7 per cent were less than seven months of age and 22.9 per cent were seven to twelve months of age. Approximately 90 per cent of the mortalities were in infants less than one year of age.

4. There is still a marked seasonal fluctuation of the disease with most of the cases occurring in July, August, September and October, the peak being reached in August. There seemed to be a rough correlation between the incidence and prolonged heat waves of 85° F. or more.

5. Parenteral infections were very common among the enteritis patients, occurring in 74.8 per cent of a group of 683 infants. These infections were more than twice as numerous among the infants under one year of age as in older children, but there was insufficient evidence that they were etiologic factors leading to the gastro-enteritis symptoms.

6. In certain epidemics, specific bacteria other than the typhoid and dysentery group apparently invade the intestinal tract to produce symptoms of gastro-enteritis.

7. The rôle played by the infant's diet in causing gastro-enteritis was uncertain, but it was interesting that only 8 per cent of the group were breast-fed.

8. In the treatment of these patients, food was withheld as long as possible. Infusions of physiologic saline and glucose solutions and blood transfusions were employed vigorously to combat dehydration and to supply sufficient nutritive matter.

9. The continuous intravenous therapy, first recommended for the treatment of gastro-enteritis of infants by Karelitz and Schick, is a rapid and

effective method of combating toxicity and dehydration.

10. Seventeen infants with very severe gastroenteritis, toxicity and dehydration were treated with this method. There was generally a marked improvement after 500 to 1000 cc. of fluid had been administered. The disappearance of dehydration and the increased tolerance for liquids by mouth were the two most striking clinical observations. The mortality rate of this group was 47 per cent.

11. The treatment is less effective in infants with severe respiratory infections, especially pneumonia.

12. Dangers from this method arise from (1) too rapid or irregular flow of the fluid; (2) the development of phlebitis; (3) dilution of the blood proteins causing generalized edema; (4) circulatory failure. Careful observation and immediate adjustment or removal of the appartus when such symptoms occur will prevent serious complications.

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STRANGULATED INGUINAL HERNIAS IN INFANTS

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REPORT of a case in an infant three months of age.

Inguinal hernia in infants and children differ from the adolescent and adult types in several ways. At the age of two years the infant becomes a child, and at twelve the child becomes an adolescent.

The inguinal canal is comparatively much shorter in children than in adults. In infants it is nearly straight, and the internal and external rings are almost on the same plane. Macready states that the canal at birth is no longer than the thickness of the abdominal wall.

Practically all hernias in infants and children are oblique. Direct hernias are very rare. In 4,114 operations on patients under 14 years of age, Coley and Hoguet found 12 direct hernias.

Inguinal hernias are most common in premature infants or in those who are underweight and whose muscles are poorly developed or weakened from disease and unable to withstand the increased intra-abdominal pressure of crying, colic, flatulence, bronchitis, whooping cough, etc.

Perhaps the most important cause of hernia in the infant is defective development. The testicle, primarily formed just below the kidney, migrates to the scrotum, where it should be by the ninth month of intrauterine life. Preceding it, in its descentis is a pouch of peritoneum, which afterwards becomes obliterated at its uppermost part. This tubular process is the tunica vaginalis. The descent of the ovary in the female is identical, except that it does not pass outside the abdominal wall. The pouch of peritoneum does pass through the wall, and if unobliterated renders the female liable to the formation of hydrocele in the inguinal canal. The descent of the testicle may be retarded or stopped altogether, at most any point in its transit. Where this organ reaches its normal abiding place in the scrotum, the pouch of peritoneum which lies in front of and along the cord to the abdominal cavity, may not be obliterated. It is this lack of complete development that is placed first in the causes of hernia in children.

The early incident of a strangulation is related to the attempt at natural closure of the processus vaginalis. The local evidence of the attempt is a fibrous ring. This seems to be the constricting factor producing the strangulation.

Small intestine is the sole content of the sac in 90 per cent of the hernias in infants and children. Omentum is next in frequency. Other viscera that are sometimes found in the sac are: Cecum, appendix, sigmoid, colon, bladder, ovary, tubes, uterus, and in rare instances, the stomach, liver, kidney, pancreas, and ureter may be found. Intrasaccular adhesions are rare in children. If any of these organs are in the sac, there may be unusual symptoms referred to the viscera involved.

The symptoms of reducible inguinal hernia in infants are usually confined to irritability, constipation, and colic. The infant cries more than usual, and is underweight and takes food badly.

In male infants, palpation of both spermatic cords often shows one to be the larger. In fat babies under one year, the cord is short, the testicles drawn up, and diagnosis is frequently difficult. After one year, the scrotum is more pendulous, and the cord is longer.

Many of the symptoms in children are similar to those in adults. The child is backward in his studies and cannot participate in active games with other children. At times they have a decided limp with some pain in the affected side.

The hernia is usually small and confined to the inguinal canal or to the upper part of the scrotum. The pillars of the external ring are often poorly developed and relaxed. For this reason, when the hernia is large and of the scrotal variety, it frequently strangulates.

If the child does not cough, and cannot be in-

duced to cry, if pressure is made over the abdomen with the palm of the examiner's open hand, the hernia will usually descend. If the external ring is dilated and relaxed, the index finger can sometimes be introduced into the inguinal canal and follow the cord up to the internal ring. Because the inguinal canal passes directly backward, it is often impossible to differentiate an oblique hernia from a direct hernia.

In female children it is sometimes difficult to locate the external ring, and the hernia does not descend as readily or as far as in male children. If it is irreducible, it sometimes contains the ovary and tube, and in rare instances, the uterus. As a rule, the diagnosis in both infants and children is simple. Hydrocele of the cord, or of the canal of Nuck, occurs frequently and is to be differentiated from hernia.

In infants and children a hernia is sometimes translucent on account of the thinness of the intestinal walls; this fact should be remembered in differentiating hydrocele and hernia. Hess suggested a rectal examination to aid in differentiating strangulated hernia from hydrocele. This method is only applicable to infants and young children in whom the examining finger can reach the os pubis.

When an infant or child complains of pain in a hernia or undescended testicle, appendicitis should always be suspected. Veau reported 53 cases of appendicitis and hernia operated on in infants and children. He found it very difficult, as a rule, to remove the appendix through the hernial incision in those under four years of age. The double operation is ordinarily to be preferred.

Strangulation may occur any time after birth. In infants the most striking symptoms of strangulation are: Profound collapse, with rapid, thready pulse, and cold, damp extremities; vomiting, first of stomach contents, followed by intestinal contents; and violent, continuous and uncontrollable screaming. Ingham reported a child who screamed continuously for thirty-six hours until relieved by operation. There is always constipation and scanty urination, sometimes retention of urine. The symptoms in children, especially the older ones, are similar to those found in adults. Johnson reported the case of an infant three weeks old in whom strangulation of an inguinal hernia took place during a tetanic convulsion.

According to Flament, the mortality of untreated strangulation in infants is 37 per cent after the first twenty-four hours, 54 per cent after forty-eight hours, and 78 per cent after seventy-two hours.

Owing to the fact that patency of the processus vaginalis exists at birth in 50 per cent of infants, hernia is most frequent during the first few months of life. By the end of the first year, spontaneous obliteration of the processus vaginalis has taken place in a majority of infants, when hernia rapidly decreases in frequency.

Macready reported 17,538 inguinal hernias occurring in males. Of these 3,158 first appeared during the first year of life; 670 between the first and fifth years, and 390 between the sixth and tenth years.

Ochsner states that 95 per cent of all hernias in infants and young children will close spontaneously if the intra-abdominal pressure is lessened sufficiently to keep the sac empty. This is accomplished by a restricted diet, the prevention of coughing, and by keeping the little patient in bed with the foot of the bed elevated. Sometimes fourteen hours' sleep each night, with the foot of the bed elevated, will keep the sac empty.

The treatment of strangulated inguinal hernias is operative. Great care must be taken in operating on infants and young children for hernia. The structures are very delicate, and are easily torn by careless or rough dissection and retraction. Only a very short skin incision is required, not over one and a half inches (4 cm.) long, and it should not extend below the external ring on account of the danger of urine infection. In freeing the sac from the tiny vas deferens, the greatest skill is required.

The modified Bassini operation is done as described for the adult. On account of the short canal, one or two deep sutures are sufficient in infants, and two or three in older children. The cord can be transplanted without injury if the dissection is carried out very gently.

Some operators are content with a simple ligation of the sac that leaves the cord undisturbed. It is usually not necessary to overlap the aponeurosis of the external oblique, unless it has been stretched by a large hernia. The subcutaneous tissues and skin are closed without drainage.

A waterproof dressing for the wound is essential to prevent contamination by urine and feces. If care is observed there will be slight danger of the wound becoming infected from the urine.

Stiles reported 360 infants and children operated on for inguinal hernia, with five deaths due to the operation, and four recurrences. Salzer reported 352 infants and children operated on for inguinal hernia with three deaths. Kovacs reported 232 patients operated on for inguinal hernia with one death, due to the operation; of 144 patients traced, there was one recurrence. Pfaehler reported 46 patients operated on for inguinal hernia, with no deaths, and one recurrence.

Infants are only slightly inconvenienced by operation. They are able to nurse soon afterward, and can be given to the care of their mothers almost immediately. Older children sometimes require a dose or two of paregoric for the pain and restlessness.

The head of the bed is kept elevated, so that when the child urinates there is less danger of contaminating the wound. Children who can walk alone should be kept in bed one to two weeks.

Reed states that postoperative increased intra-abdominal tension, when due to constipation and

flatulence, can often be relieved in infants by reducing the amount of protein in the diet and giving more cream.

REPORT OF A CASE

A baby boy three months of age was brought to my office on September 28, 1930. His mother gave the following history:

Baby was born normally on June 26, 1930. A few days after birth she noticed a small "lump" in the right groin, when the baby cried. This "lump" became fixed three times before admission, but each time the mother gently massaged it and it disappeared. On September 26, two days before admission the "lump" became fixed and she could not reduce it by massage. The baby's bowels moved that day. The following day lump was slightly red and the baby cried when she massaged that area. Bowels did not move the second day and child vomited once. The following morning she decided to seek medical aid and brought the child to my office. There was no history of previous illness.

Physical Examination—Restless, fretful male baby about three months of age. Healthy in appearance. Head, throat, ears and nose normal. Chest clear. There was a mass in the right inguinal region about the size of a large egg. It was bluish red in color and slightly firm. It was fixed and tender. Some fluctuation present over the darkest portion. The left testicle had descended into the scrotum but the right one could not be located. Temperature 38.6, pulse 120. Diagnosis: Strangulated inguinal hernia right, operation advised.

Patient was taken to hospital immediately and operated under light ether anesthesia. Dr. C. C. Higgins of the Cleveland Clinic and myself performed the operation. His operative note is as follows:

Under ether anesthesia, an oblique incision over the right external ring was made, after preparation of the skin with iodine and alcohol. Upon dissection down to the sac, it was observed that a loop of bowel contained therein was deep purplish to black in color. There was a slightly foul odor observed. One area of the bowel, the size of a five-cent piece, was deeply black. After blunt dissection to free the ring, hot wet compresses were applied to the loop for several minutes. This procedure resulted in a marked change in the color of the loop which became a dusky red. The black area changed to a deep purple. As this section of the bowel appeared to be smooth and glistening, the operator expressed the opinion that it would return to normal, despite the dusky color. The loop was returned to the abdomen with some difficulty through the narrow ring, after which the testicle was discovered lying free along the canal, having been partially undescended. The hernial sac was now closed by sutures. The spermatic cord was elevated, and the fascia of the right rectus, with the conjoined tendon, was stitched over to the shelf of Poupart's ligament with interrupted chromic sutures. A space was now produced in the scrotum by blunt dissection with the finger, and the testicle drawn down into space. The fascia of the external oblique was brought over to Poupart's ligament, where it was held by interrupted chromic sutures. The skin was closed with a few black silk sutures and large clips. The patient left the table in fair condition.

Following the operation the pulse rose to 156 and respiration to 48, temperature 38.5. The baby vomited several times that night. The following day the pulse continued to be rapid (120 to 140), respiration 20 and temperature same. A warm soda enema was given which returned slightly colored. The abdomen seemed distended and slightly tympanitic in the morning, gradually increasing throughout the day. Proctoclysis of 5 per cent glucose was given. Hot turpentine stupes were applied to abdomen following which the tympanites diminished. The second day symptoms were gradually increasing temperature rising to 39. Saline infusions and routine of the previous day did not seem to relieve. Emesis continued off and on with a resultant fecal vomitus. Symptoms continued to increase until death on the morning of the fourth day following operation, death being caused by intestinal obstruction. Autopsy could not be obtained.

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—O S M J—

Dr. Arnold Jackson, 16 South Henry Street, Madison, Wisconsin, is conducting a nation-wide survey on the incidence of cretinism and is anxious to obtain information from any Ohio physicians who might have records of such cases. When this data is compiled, Dr. Jackson says he intends to turn it over to the American Medical Association for further reference and study.

—O S M J—

Improved economic conditions are credited by the Cleveland Community Fund for the 17 per cent gain in income from patients registered by the Cleveland hospitals receiving community fund aid in January, 1934, compared to January, 1933. The fund reported also that payments on delinquent hospital bills have increased.

MANY POLICY PROBLEMS, ANNUAL MEETING PLANS AND NUMEROUS OTHER IMPORTANT MATTERS ACTED ON BY THE COUNCIL

MINUTES

The Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, at 1:00 P. M. on Sunday, March 11, 1934.

Officers, Councilors and committeemen present were: President, Dr. Cummer; President-Elect, Dr. Caldwell; Ex-President, Dr. Platter; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Paryzek, Davidson, Brush, Seiler and Goodman; Dr. Stone, chairman, Dr. Alcorn and Dr. Upham, members, Policy Committee; Dr. Rogers, chairman, Publication Committee; Dr. Bigelow, former president; Dr. Southard, State Director of Health; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on December 17, 1933 (pages 39 to 44, inclusive, of the January, 1934, issue of *The Journal*), were read, and on *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, were *approved*.

1934 ANNUAL MEETING PROGRAM DETAILS

Dr. Paryzek, the chairman of the Council Program Committee, reported in detail on progress to date in the formulation of the program for the General Sessions for the forthcoming annual meeting in Columbus on Thursday, Friday and Saturday, October 4, 5 and 6, 1934. He also reported in detail on conferences and correspondence with Section officers and on the action and deliberations by the Program Committee at a meeting on the morning of this day, showing considerable progress in the formulation of the Section programs.

On recommendation and *motion* by Dr. Paryzek, seconded by Dr. Klotz and *carried*, the Council authorized the Program Committee to establish as the deadline date April 20, 1934, for the submission by the Section officers of their respective Section programs for consideration by the Program committee and the Council.

Dr. Paryzek also recommended for consideration of officers of the Columbus Academy of Medicine the creation of special local committees for the annual meeting as follows: 1. A reception committee to receive and take charge of the out-of-state speaker guests; 2. A special local committee on clinical material whose duty it shall be to contact in advance the out-of-state speakers for the General Sessions and to provide clinical material for the speakers for their scheduled subjects and demonstrations; 3. A local scientific exhibits committee. By action of Council, authorization was given to the Program Committee to convey these recommendations and requests to the Columbus Academy of Medicine.

A suggestion was also submitted by Dr. Paryzek for the employment of a medical stenographer for the out-of-state speaker guests who are scheduled for clinical demonstrations, rather than formal papers, which could not be expected to be prepared in manuscript form. The Council requested Dr. Paryzek to make further detailed recommendations on this point at the next Council meeting.

On *motion* by Dr. Paryzek, seconded by Dr. Huston and *carried*, the detailed report by Dr. Paryzek was *approved*.

Dr. Goodman, chairman of the Council Committee on Arrangements reported on a meeting of his committee held on the morning of this day, and on *motion* by him, seconded by Dr. Davidson and *carried*, the Council *approved* the selection of the Neil House, Columbus, as the headquarters and meeting place for the coming annual meeting of the State Association.

PROBLEMS OF EMERGENCY RELIEF AND MEDICAL CARE

The President, Dr. Cummer, reported in detail on a recent conference held with Governor White, at which conference there was emphasized the prolonged delay in action by the State Relief Commission following correspondence, other contacts and requests for modification of the plan and fee schedule for the care of the needy unemployed, as officially presented to the Commission by the Council of the Ohio State Medical Association. In addition to a discussion of medical relief problems, Dr. Cummer summarized problems of Civil Works Administration and workmen's compensation, which were included in the conference with the Governor. (There are published elsewhere in this issue of *The Journal*, and by this reference made a part of these minutes, details on the conference with the Governor and preceding and subsequent developments).

At the request of the President, several members of Council reported on problems and developments in the counties in their respective Districts in relation to the Civil Works Administration and medical care of the needy.

Official Statement Adopted by Council

Dr. Stone, chairman of the Policy Committee, reported on developments in connection with the State Relief Commission and local developments in the care of the needy since the last Council

meeting and on the deliberations of his committee held on the preceding evening.

On behalf of the Policy Committee, Dr. Stone presented a detailed formal statement for the consideration of the Council.

This statement, published elsewhere in this issue of *The Journal*, and by this reference made a part of these minutes, was, on *motion* by Dr. Huston, seconded by Dr. Paryzek and *carried* unanimously, adopted as the official expression and sentiment of the Council.

After discussion by Councilors as to proper means for conveying information on this action to the membership generally before the publication of the next issue of the *Ohio State Medical Journal*, on *motion* by Dr. Goodman, seconded by Dr. Smith and *carried*, the Executive Secretary was instructed to send copies of the official statement adopted by the Council on this subject to the membership of the State Association as promptly as possible under first-class postage.

CWA Medical Problems

Reports were submitted by several Councilors on local developments in connection with medical service to injured employes of the Civil Works Administration.

On behalf of the Policy Committee, Dr. Stone presented a written statement on problems of medical service in connection with the CWA administration. This statement, published elsewhere in this issue of *The Journal* and hereby made a part of these minutes, was, on *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, adopted as the official expression of the Council.

IMPORTANT WORKMEN'S COMPENSATION DEVELOPMENTS

Dr. Hein, chairman of the special Council Committee on Workmen's Compensation, and Dr. Stone, chairman of the Policy Committee, reported in detail on recent developments pertaining to workmen's compensation administration, especially in relation to the payment of medical fees for services rendered. Reference was made to a resumé of the situation published on pages 171 to 173, inclusive, of the March, 1934, issue of *The Journal*. Dr. Hein's report included a tabulated comparison over recent months in the amount of premium payments by employers and expenditures for medical, nursing and hospital service.

Dr. Stone presented a written report and statement on behalf of the Policy Committee. That statement follows:

Report and Statement

(a) The efficiency of the entire workmen's compensation structure depends on the medical profession. Prompt and efficient medical treatment, periods of disability, including compensation to injured workmen, shortening of the periods of rehabilitation, problems of prospective periods of disability, degree of disability and eventually even the amount of premiums and the status of the fund itself depend on competent, qualified, honest medical service.

(b) In view of the fact that an investigation is proposed of administrative procedure in connection with workmen's compensation, a number of members of the medical profession have felt that a physician should be designated as a member of the Governor's investigating committee.

(c) An alternative suggestion is recommended of the designation of an official or an unofficial observer to represent the State Medical Association with a voice at all sessions of the committee, even executive sessions, when any questions of medical treatment or medical administration in connection with workmen's compensation are under consideration.

(d) Reference is herein made to action by a special committee of the Ohio State Medical Association, including the report and recommendations approved by the Council, published on pages 378 and 379 of the June, 1933, *Journal*.

(e) The willingness and desire of the State Medical Association to cooperate with the Governor and his workmen's compensation committee in improvement of administrative procedure and in elimination of abuses, is hereby expressed, as well as a desire to cooperate with the special Senate investigation committee and all others earnestly concerned with problems of workmen's compensation administration.

On *motion* by Dr. Caldwell, seconded by Dr. Paryzek and *carried*, the foregoing report and statement was adopted as official by the Council.

UNOFFICIAL UNAUTHORIZED STATEMENTS

Dr. Hein called attention to recent newspaper interviews by Dr. Goodman referring to official investigation of workmen's compensation administration and in which reference was made to previous action by the Council of the Ohio State Medical Association containing recommendations for improvement in administrative procedure in the State Department of Industrial Relations.

On behalf of the Policy Committee, Dr. Stone presented the following report and recommendations:

WHEREAS, A member of Council in published newspaper interviews recently undertook to interpret policies and activities of the Ohio State Medical Association without authorization from the Council, and in which his official position was emphasized, thus adding public interest and news value to such interview, in spite of his declaration that he was speaking only as an individual member, and,

WHEREAS, Such interview was not truly representative of official action taken and policies expressed by the Council,

THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association officially disapprove of the issuance for publication or public circulation of statements by any officer or committeeman when such official position is announced, until or unless officially authorized to make such public statement by the Council. In cases calling for public announcement when there is no opportunity for Council action, the President only is authorized to speak for the State Medical Association and then only in accordance with action officially taken by the Council or the House of Delegates. In cases where unsolicited information is sought by news writers or others

from the headquarters office of the State Association, the Executive Secretary only is authorized to issue information, and then only "from the record" based on official action by the Council or the House of Delegates.

Following discussion, on *motion* by Dr. Hein, seconded by Dr. Brush and *carried*, the Council adopted the foregoing resolution.

GROUP MEDICAL PRACTICE PROBLEMS

There was presented on behalf of the Policy Committee by the chairman the following proposed statement of principle:

Attention of the Council has been called to proposals to establish in some communities group or other insurance plans at stipulated monthly or yearly premiums to cover, through mutual funds, the medical care to the individuals who become policy-holders.

The Medical Economics Committee of the American Medical Association has assembled data on a number of these projects. Before officially participating in any of these local endeavors, the Council recommends to the county medical societies and academies of medicine that consideration be given to:

a. Practicability and security of any such fund in addition to the honesty and integrity of the promoters.

b. The details of the plan, including solicitation of policy-holders, actuarial data, and provision for financial reserve, as well as definite provisions for audit of such funds.

c. The degree of participation and authority by the medical profession in the control and management of the plan.

d. Whether the promotion costs are out of proportion with the fund to be disbursed to physicians for actual medical service rendered.

e. Whether or not such a plan will tend to establish in a community a definite schedule of medical fees and to leave the impression with the public that certain fees would be recognized as setting the value of various types of professional service.

f. Whether or not such plan would include evil effects of corporate practice of medicine, or develop questionable types of contract practice.

g. Whether any such plan would probably or inevitably lead to advantage among individual physicians or small groups of physicians to monopolize the medical service to beneficiaries of the insurance fund, or would tend to interfere with the free choice by the policy-holder of his own physician.

h. Whether corporate, commercial, lay control will inevitably develop to destroy the ethical and confidential relationship between physicians and patients to the destruction of free competition among physicians of a community as contemplated under the Principles of Ethics.

It is the sense of the Council of the Ohio State Medical Association that before county societies or academies of medicine approve of, or lend support to, group insurance plans under lay or commercial control, serious consideration be given to the implications contained in any program which would supersede private medical practice or establish a middleman service between patient and doctor. The Council is not convinced from the information and data at hand that private medical practice when ethically and efficiently conducted has failed to meet the social, economic and medical demands of a community.

On *motion* by Dr. Davidson, seconded by Dr. Brush and *carried*, the Council adopted the foregoing statement as its official expression on this subject.

GROUP INSURANCE PLANS

Dr. Paryzek reported on developments in Cleveland on the group hospital insurance proposals which have been formulated by the Cleveland Hospital Council and referred to on pages 113 and 114 of the February, 1934, issue of *The Journal*.

Dr. Smith and Dr. Caldwell discussed developments in Cincinnati on proposals for hospital group insurance.

In connection with the discussion attention was called to the statement adopted by the Council of the State Association at its meeting on October 29, 1933, published on page 777 of the December issue of *The Journal*.

CLINIC AND INSTITUTIONAL ADVERTISING

Dr. Huston presented information and referred to correspondence in relation to a pending resolution in the Montgomery County Medical Society on clinic and institutional advertising, and presented for the consideration of the Council the following resolution:

WHEREAS, There exists an ever-increasing spirit of resentment in the ranks of the individual practitioners of medicine throughout the country, who are constantly exhorted to respect and foster the recognized ethics of the profession, against the liberty taken by certain large clinics in their disregard of the honorable restrictions placed upon the individual physician, therefore,

BE IT RESOLVED, That the Council of the Ohio State Medical Association direct the Ohio delegation of the American Medical Association to present to the House of Delegates of the American Medical Association at its meeting in Cleveland, a resolution of protest against the growing practice of advertising by several of the large clinics now practicing medicine and surgery in the Unitel States.

Following discussion, on *motion* by Dr. Huston, seconded by Dr. Smith and *carried*, the foregoing was officially adopted by the Council.

On behalf of the Policy Committee, Dr. Stone presented the following resolution on the same general problem:

WHEREAS, The attention of the Council has been called to advertising and publicity by clinics and medical institutions, and

WHEREAS, The Council of the Ohio State Medical Association at its meeting on December 14, 1930, issued an official statement and analysis on advertising ethics;

THEREFORE BE IT RESOLVED, By the Council of the Ohio State Medical Association, that such statement, published on pages 60 and 61 of the January, 1931, issue of *The Journal*, be again reaffirmed and emphasized; as well as to reaffirm the resolution adopted by the House of Delegates of the American Medical Association in 1924 submitted by Dr. Geo. Edw. Follansbee by direction of the House of Delegates of the Ohio State Medical Association, reading in part as follows:

"1. Publicity by clinics, hospitals, sanatoriums and other semi-public medical institutions as to

quality of work done implies unusual and exceptional ability and efficiency on the part of their professional staffs and therefore is advertising of the medical men concerned. This type of advertising distinctly savors of quackery and is unethical.

"2. Publicity by any such institution stating or implying that by reason of its exceptionally fine equipment and material resources, it is able to, or does, give the public better medical service than similar institutions are able or willing to render, is advertising for purposes of self-aggrandizement. Statements of this type are frequently exaggerated and misleading, are detrimental to the best interests of the public, of the institution concerned, and of true medical progress. Publicity of this kind is unethical."

On *motion* by Dr. Smith, seconded by Dr. Davidson and *carried*, the foregoing Policy Committee resolution was adopted by the Council.

SECRETARY OF COUNCIL

Dr. Goodman submitted his verbal resignation as Secretary of Council. Following discussion, on *motion* by Dr. Davidson, seconded by Dr. Caldwell and *carried*, Dr. Goodman's resignation as the Secretary of Council was accepted.

Dr. Davidson nominated as Secretary of Council to serve until the next annual meeting, Dr. James A. Beer, Columbus, Treasurer of the Ohio State Medical Association. There being no further nominations, on *motion* by Dr. Brush, seconded by Dr. Davidson and *carried*, the Secretary was instructed to cast the ballot of Council for Dr. Beer as Secretary of Council.

PROBLEMS OF TAXATION

The Policy Committee presented for discussion of Council information on pending legislation in the Ohio General Assembly in reference to taxation. The Council reaffirmed its previous policy in the avoidance, if possible, of a duplication of tax impositions on physicians (page 42, January, 1934, issue of *The Journal*).

MEDICINAL LIQUOR

The Policy Committee presented for the information and discussion of the Council an analysis of some of the proposed amendments to the present State Liquor Control Act and reference was made to the action by the Council on this subject at its last meeting (page 41, January, 1934, issue of *The Journal*).

On *motion* by Dr. Huston, seconded by Dr. Caldwell and *carried*, the Council reaffirmed the policy that the medical profession should *not* be limited by statutory restrictions on the quantity, frequency or dosage of any medicine in the scientific treatment of patients.

APPROVAL OF COUNTY SOCIETY AMENDMENTS

On behalf of the Judicial Committee of the Council, the President submitted a proposed amendment to the By-Laws of the Wayne County Medical Society as proposed for inclusion by that society to provide for a standing Committee on Public Health and Public Relations in that society.

On *motion* by Dr. Davidson, seconded by Dr. Klotz and *carried*, the Council *approved* such amendment.

On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the Council again reaffirmed and re-emphasized its recommendations to the county societies that standing committees be created by resolution or otherwise in each county society on problems of public relations, economics or civics (the function of such committee being well understood and the exact title of the committee being left to the choice of each society).

A. M. A. MEETING IN CLEVELAND

Dr. Stone, General Chairman of the committees on arrangement for the forthcoming annual session of the American Medical Association in Cleveland, June 11 to 15, requested action by the Council in the selection of representatives from the Council or the State Association to serve as co-chairmen on three of the local committees, as follows: a. Finance Committee; b. Entertainment Committee; c. Committee for the President's Reception and Ball.

On *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the President was authorized and empowered to make such appointments at an early date.

MEMBERSHIP STATISTICS

A report submitted for the information of the Council showed the receipt of 1934 membership dues to date for 4,316 members, as compared with 4,173 on the same date last year and as compared with a total of 5,183 for the year 1933. Dr. Cummer, the President, emphasized to the Councilors the importance of stimulating interest by direct contact with county society meetings, correspondence and otherwise, in the maintenance of membership, as well as the duties of Councilors through such contacts and communications in emphasizing and interpreting to the county societies action taken by the Council at this meeting on a number of important matters, particularly in reference to emergency relief, medical care of the needy, medical service in connection with CWA, and workmen's compensation administration.

MISCELLANEOUS

A communication was presented from Mr. B. W. Stewart, Youngstown, President of the Ohio Hospital Association, requesting information on administrative and professional relations between hosiptals and the medical profession. On *motion* by Dr. Caldwell, seconded by Dr. Klotz and *carried*, the Executive Secretary was instructed, with the cooperation and approval of the President and Chairman of the Policy Committee, to submit information to Mr. Stewart.

A communication was presented from Dr. R. E.

Hershberger, secretary-treasurer of the Seneca County Medical Society, relative to "honorary memberships". On *motion* by Dr. Caldwell, seconded by Dr. Paryzek and *carried*, this correspondence and this question were left to the Judicial Committee of the Council for consideration and report at a later meeting.

A communication was presented from Mrs. August, secretary of the Ohio State Nurses' Association, in relation to nursing problems, particularly governmental questions of relief to the needy, nursing under the CWA, and similar matters. The Council expressed interest and cooperation, and the Policy Committee was authoried to cooperate with the officers of the Ohio State Nurses' Association in accordance with policies already expressed.

There was presented to the Council a communication from Dr. J. B. McMillen, Somerton, suggesting a proposal for a distinctive designation on next year's state automobile license tags for physicians. This matter was discussed, but no action taken by the Council at this time.

A communication was presented from Dr. F. S. Van Dyke of the Stark County Medical Society, in relation to a correct "medical emblem" when used in *The Journal* and otherwise officially by the State Medical Association. By authority of the Council, the President referred this matter to Dr. Rogers, chairman of the Publication Committee, for consideration and later report.

The Council adjourned to meet at the call of the President.

Signed,
JAMES A. BEER, M.D.,
Secretary of Council.

—O S M J—

Youngstown Post-Graduate Day

Annual Post-Graduate Day sponsored by the Mahoning County Medical Society will be held Saturday, April 28, at Youngstown. The program will be presented by Dr. J. C. Meakins, Dr. Wilder G. Penfield, Dr. J. B. Collip, and Dr. John R. Fraser of the medical faculty, McGill University, Montreal, Canada. Each will deliver two lectures as follows: Dr. Meakins: (1) Rheumatic Fever Considered as a Specific Infectious Disease and Its Prognosis and Treatment; (2) Chronic Non-Tuberculous Pulmonary Disease. Dr. Penfield: (1) Management of Head Injury, Early and Late; (2) Epilepsy—Classification and Management. Dr. Collip: Recent Advances in Anterior Pituitary Physiology (two lectures). Dr. Fraser: (1) The Inflammatory Pelvis; (2) Haemorrhage in the Last Trimester of Pregnancy.

—O S M J—

Mercy and General hospitals, Portsmouth, and St. Joseph's Hospital and Gates' Hospital for Crippled Children, Elyria, were among the beneficiaries of the $1,500,000 charity bequests made by the late Henry C. Richman, Cleveland.

Program for Annual Tri-State Meeting, April 10, at Flint

Official program for the Sixty-First Annual Meeting of the Northern Tri-State Medical Association, April 10, at Hurley Hospital, Flint Michigan, is as follows:

8 a. m.—Dr. William Clift, Flint, "Upper Cervical Dislocations".

8:15 a. m.—Dr. A. Dale Kirk, Flint, "Infant Mortality".

8:30 a. m.—Dr. M. S. Chamber, Flint, "Principles in Treatment of Diseases of the Heart".

8:45 a. m.—Dr. George Curry, Flint, "Musculo-Spinal Paralysis".

9 a. m.—Dr. Carl A. Hedblom, Chicago, professor of surgery, University of Illinois, "The Selective Surgical Treatment of Pulmonary Tuberculosis".

9:45 a.m.—Dr. Clifford G. Grulee, Chicago, professor of pediatrics, Rush Medical College, "Some Interesting Conditions in the Newly-Born Infants".

10:30 a.m.—Dr. William M. Donald, Detroit, professor of medicine, Detroit College of Medicine and Surgery, "What to do When the Diabetic Comes".

11:15 a.m.—Dr. George C. Hale, professor of medicine, University of Western Ontario, "Sleep".

12 m.—Luncheon.

1 p. m.—Dr. Arthur E. Hertzler, professor of surgery, University of Kansas, "Management of Goiter".

1:45 p. m.—Dr. Norman F. Miller, professor of obstetrics, University of Michigan, "The Anticipation and Management of Toxemia of Pregnancy".

2:30 p. m.—Dr. Herman L. Kretschmer, professor of urology, Rush Medical College, "Changing Trends in the Treatment of Prostatic Obstructions".

3:15 p. m.—Business Session.

3:30 p. m.—Dr. Louis J. Hirschman, professor of proctology, Detroit College of Medicine and Surgery, "The Sclerosing Treatment of Hemorrhoids, Its Indications and Limitations".

4:15 p. m.—Dr. Wilder Groves Penfield, professor of neurological surgery, McGill University, "Epilepsy".

6 p. m.—Banquet. Address, Dr. Harry E. Mock, associate professor of surgery, Northwestern University, "How Can High Mortality in Skull Fractures be Reduced".

Officers of the association are: President, Dr. G. O. Larson, LaPorte, Ind.; vice president, Dr. Edward P. Gillette, Toledo; secretary, Dr. G. E. Jones, Lima; treasurer, Dr. H. F. Randall, Flint; counsellors, Dr. Charles Lukens, Toledo; Dr. P. N. Sutherland, Angola, Ind., and Dr. W. M. Donald, Detroit.

INCREASED FEE SCHEDULE FOR MEDICAL CARE TO THE NEEDY ANNOUNCED BY THE STATE RELIEF COMMISSION; COUNCIL ACTIONS SUMMARIZED

A modified and increased fee schedule for medical care of the needy from state-federal relief funds, effective April 1, 1934, was announced by the State Emergency Relief Commission under date of March 17.

This action was taken by the Commission after six months of constant activity and repeated demands on the part of the officers, the Council, and committees of the Ohio State Medical Association, backed by concerted action by county medical societies, and upon emphatic appeal made to Governor White, for proper improvement in the temporary plan and fee schedule established last September by the Relief Commisson governing the expenditure of state-federal funds for medical care to recipients of unemployment relief.

The principal changes in the revised medical relief set-up (announced in Revised Ohio Supplement No. 1 to Federal Relief Administration Rules and Regulations No. 7) approach some of the important recommendations for modification and adjustments made by the Council of the Ohio State Medical Association in official action at its meeting on December 17, 1933, (page 40, January, 1934, issue of *The Journal*) and officially transmitted to the State Relief Commission on December 19, 1933.

CHANGES IN FEE SCHEDULE ANALYZED

The important provisions of the revised medical fee schedule are as follows:

1. The fee for an office call is increased from 50 cents to $1.00.

2. The fee for a house call within a radius of one mile from the physician's office is increased from $1.00 to $2.00 and provision is made for a fee of $2.50 for such house call if made between 9 p.m. and 7 a.m.

3. Adjustment is made in the allowances for mileage for house calls more than one mile from the physician's office. Under the revised fee schedule, the physician is entitled to mileage at the rate of 25 cents per mile (one way and not including the first mile) with a maximum mileage allowance of $3.00 for the first 15 miles and to a mileage allowance at the rate of 10 cents per mile after the first 15 miles. Under the previous fee schedule, the physician was permitted mileage at the rate of 25 cents per mile but the maximum charge for any one call (regular fee plus mileage) was previously fixed at only $2.00, which in effect limited the physician to a mileage allowance of only $1.00 for any one call regardless of distance. The mileage allowance set-up in the new, revised fee schedule is exclusive of the regular fee for house calls and is a more equitable compensation arrangement, especially for physicians in rural communities. Instructions issued by the Commission provide that physicians, where possible, must group cases by days and trips so as to eliminate unnecessary mileage, and the local relief director is authorized to reduce mileage allowances where there is an obvious overlapping.

4. The revised fee schedule provides that the physician shall furnish ordinary medication and supplies at his own expense but that *in cases requiring SPECIAL DRUGS OR SUPPLIES, the physician may request from the local relief administration authorization to purchase and use such SPECIAL DRUGS OR SUPPLIES and shall be reimbursed for the cost of such drugs and supplies.* As summarized in the revised fee schedule, SPECIAL DRUGS OR SUPPLIES for which the physician is entitled to reimbursement at actual cost, are interpreted to mean:

(a) Any drug such as those supplied in ampuls or vials costing 50 cents or more (catalogue price) for one treatment or injection.
(b) Any capsule, tablet, powder, etc., costing more than 50 cents a dozen. (Actual cost price to the physician).
(c) Any liquid medicine costing more than 50 cents for 4 ounces. (Actual cost price to the physician).
(d) Any ointment costing more than 50 cents for 2 ounces. (Actual cost price to the physician).
(e) Any tampon, dressing or suppository costing more than 50 cents each. (Actual cost price to the physician).
(f) Any special splint, not including simple wooden splints or appliance (these are to be rented, not purchased, whenever possible by the local relief administrator).

No bills for SPECIAL DRUGS AND SUPPLIES will be honored except those purchased upon the request of a physician.

Physicians providing authorized medical care are instructed in the Commission ruling to use a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect. Special drugs and medicine are restricted to the National Formulary or the United States Pharmacopeia. To avoid excessive expenditures for remedies of unknown or doubtful value, proprietary or patent medicines will not be authorized.

5. Provision is made that physicians shall submit itemized bills, at the end of two weeks or after five visits, to the county relief director. For this purpose official forms (Form RM or Form RO)

are provided by the relief administration. This plan for the submission of bills at regular intervals will, it is believed, speed up the payment of physicians' bills and provide local relief directors with a better check on the medical services being rendered families receiving relief.

6. Only minor changes are made in the free schedule for obstetrical care. Upon authorization of the local relief administration, Form RO, a physician may administer obstetrical care to patients eligible to emergency relief, for which the following fees will be paid:

(a) Normal delivery, $20.00.

(b) In event of the use of forceps, episiotomy, repair, or extra time exceeding 12 hours, an extra fee of $5.00 will be allowed for any one or all four of the foregoing factors but not for more than one.

7. Several changes and additions are made to that part of the fee schedule pertaining to cases requiring the services of specialists, nurses, dentists, and special drugs and supplies. In all emergencies requiring the assistance of a specialist such as an eye, ear, nose and throat specialist, surgeon, dentist or nurse, same will be called only on the recommendation of the physician in attendance who has seen the patient in his home or at the physician's office. This is not to mean that all cases needing dental care require a recommendation from a physician, but shall apply only to those cases under the care of a physician needing supplementary care of a dental nature. The physician is required to make a request for specialists, nurse and special drugs and supplies to the local relief administration in writing, verbally, or by telephone. If the request is granted, the physician should make a record of the same on Form RM or Form RO.

8. THE OHIO INDUSTRIAL COMMISSION GENERAL AND SPECIAL FEE SCHEDULES FOR MEDICAL AND SURGICAL SERVICES SHALL APPLY IN ALL CASES NOT COVERED BY ORDINARY HOUSE CALLS AS STIPULATED ABOVE. (This applies to accidents such as fractures, etc.)

9. A fee schedule governing the payment of dentists for dental care authorized by the local relief administration is established together with a fee schedule for nursing service.

DENTAL AND NURSE FEES ESTABLISHED

Under the dental fee schedule, dentists will be paid 50 cents for an extraction using local anesthetic; $2.50 additional for extraction using general anesthetic; $1.00 for a filling; 50 cents for *X*-ray film; maximum of $3.00 for repair of denture; maximum fee of $5.00 for treatment of Vincent's infection, and flat fee of $5.00 for recovery of broken roots and post-operatic treatments.

Nursing care may be authorized on Form RM by the local relief administration *on the recommendation of the attending physician* for which the following fees will be paid: City calls, flat rate per visit, 75 cents; county calls, regular rate of 75 cents per visit, plus a mileage allowance at the rate of 25 cents per mile but not to exceed $2.00. Local relief directors are given authority to reduce mileage allowances where there is an obvious overlapping and nurses are instructed to group calls by days and trips to eliminate unnecessary mileage.

LIMIT ON FUNDS MAY OFFSET FEE INCREASES

At the same time the Commission adopted the foregoing increased fee schedule, it adopted the following provision and authorized that it be incorporated in Revised Ohio Supplement No. 1 to govern the allocation of funds to the various counties for medical care:

> "Provided that at the end of each month the total expenditure for medicine, medical supplies or medical attendance shall not exceed $1.00 per month per family for the county. If the total expenditure for the month exceeds the above amount, i.e., $1.00 per month per family for the county, it shall be pro-rated".

The effect of this limitation on the amount of state-federal money to which each county will be entitled for medical care to the needy is uncertain. This inflexible budget provision may automatically force the payment of medical bills on a pro-rated basis in many counties, thereby nullifying the increased fees authorized in the revised fee schedule. It has not been made clear whether counties will be permitted to carry forward from month to month surpluses, if any, in their state-federal medical funds, in order to meet deficits in the medical fund arising from heavy incidence of sickness among those on relief; or whether such surplus can be used to pay in full medical bills previously paid on a pro-rated basis.

Should the $1-per-family-per-month arrangement result in inequities and fail to provide sufficient funds for necessary medical attention, concerted effort by the medical profession may be necessary to secure modification of the revised medical set-up by the Commission, in order to insure adequate medical care for families on relief and payment to physicians rendering such service in accordance with the increased medical fee schedule effective April 1.

GENERAL PROVISIONS OF MEDICAL PLAN

The general procedure governing the use of state-federal funds for medical care to those on unemployment relief established last September 20 when Ohio Supplement No. 1 to Federal Relief Administration Rules and Regulations No. 7 was issued is not modified in Revised Supplement No. 1.

This general plan, which applies to the use of

all state-federal funds for emergency relief *in the home* provides:

State-federal funds cannot (under present federal law and regulations) be used to pay hospital bills or operations performed in hospitals, since such charges are excluded by Federal Relief Administration Rules an Regulations No. 7.

The State Emergency Relief Commission will not assume the cost of medicines, medical supplies or medical attendance and public health work that have normally been carried by the counties and cities, but will assume that portion of this expense that has been brought about directly as a result of unemployment, when and where local funds have been exhausted.

Each case involved must be entitled to emergency relief based upon adequate investigation, and in no case does this service apply to institutional care or the normal health program of the political subdivision.

Medical service to be paid by state-federal funds must be limited to office calls or calls of the physician in the home of the family receiving relief and for special medicine and medical supplies for the family receiving relief.

Where the subdivisions have regularly employed physicians on a salary or fee basis, state-federal funds cannot be used to replace this service.

The county relief director, or proper relief official of a city, is expected to announce the revised medical relief plan to local physicians licensed to practice medicine in Ohio, through the local county medical society. Those willing to serve families receiving relief shall be given the opportunity to register with the county relief director or proper city relief official.

The family authorized by the county or city relief administration to receive medical attention shall be permitted to select a physician of its own choice from such registered list of physicians.

Only *in cases of emergency* shall families be permitted to call a physician before securing a medical order blank from the proper relief official, and then in each case an order must be secured before the second visit.

The fee schedules established by the State Relief Commission for medical, dental and nursing services shall apply only in those cases of the needy sick who are already receiving other benefits from relief funds and where provision has not been made otherwise locally for the care of these needy sick; and, further, that these fees are not intended to establish such low rates in ordinary practice.

DEMANDS FOR IMPROVED FEE SCHEDULE CLIMAXED BY COUNCIL ACTION, MARCH 11

An unprecedented number of complicated and difficult problems arising from the program set-up in Ohio last September to provide medical care for the needy have confronted the officers, the Council, and the committees of the State Association in their constant efforts to represent the best interests of the medical profession of Ohio in their contacts with state relief officials and to secure more equitable compensaton and greater appreciation for the services of the medical profession.

Serious developments, dating from September 20, 1933, when the State Relief Commission announced a temporary plan and inadequate fee schedule, and multiplying over a period of months, reached a climax on March 11, 1934, when the Council of the State Association adopted unanimously a statement on the chaotic medical relief situation and authorized that it be transmitted to members of the State Medical Association.

This statement was acted upon and approved by the Council following a thorough and prolonged discussion of the relief situation, which included reports on recent developments by Dr. C. L. Cummer, the President, members of the Council, other officers of the State Association and Dr. C. W. Stone, chairman of the Committee on Public Policy. The statement, transmitted to the membership under date of March 15, 1934, and over the signatures of Dr. Cummer, Dr. Stone, and the Executive Secretary, was as follows:

PROBLEMS IN CONNECTION WITH THE STATE EMERGENCY RELIEF COMMISSION AND MEDICAL SERVICE TO THE NEEDY POOR

We view with regret, disapproval and apprehension the accumulated evidence over a period of recent months of the disposition on the part of the State Government and State Administration to ignore important and fundamental phases of medical practice and medical service in connection with governmental functions, public health, public welfare, public safety and medical care, in spite of the fact that the medical profession, through medical organization, could be of inestimable service to state officials with information and advice. We believe that the reluctance and failure of state officials to consult with or follow recommendations of the medical profession has contributed to a chaotic situation detrimental to the public, the State Administration and the medical profession.

As members of a humanitarian profession, physicians during the prolonged period of economic distress have unselfishly contributed more to relieve illness and suffering than any other group and have received less appreciation and consideration for altruistic services rendered by them. For approximately four years the medical profession has borne the brunt of medical work for indigents for little or no compensation. Meanwhile all other purveyors of necessities to the needy have been compensated through governmental funds.

On September 20, 1933, after federal-state funds became available under the State Emergency Relief Commission to include medical services to the needy unemployed, the State Relief Commission announced a temporary plan and fee

schedule totally inadequate to carry the overhead of services rendered. *Repeated requests* were made by the State Medical Association for an official hearing with the State Relief Commission (and in spite of much correspondence, many discussions and protests to officials of the Commission), and after six months no hearing before the entire Commission has been granted, nor has any modification been made in the temporary plan and unfair fee schedule. In many communities even at the inadequate fee rate physicians are not being paid, or at best only after long delay. Official action on these matters was taken by the Council of the Ohio State Medical Association and definite recommendations were made for modification (minutes of Council meeting of October 29, 1933, pages 776 and 777 of the December, 1933, issue of *The Journal*). At its meeting on December 17, 1933, the Council again took official action (page 40, January, 1934, *Journal*), requesting an adjustment and improvement in the fee schedule. These and other actions by the Council and officers of the State Association were officially communicated to the State Relief Commission, but with no result.

On February 26, 1934 (after earlier requests from officials of the State Medical Association), a conference was secured with Governor White, at which protest was voiced at the lack of appreciation by the State Administration for the essential value of medical service or for the opportunity, offered from time to time, to benefit by information and advice from medical organization on problems of essential medical care.

Data assembled show that relatively higher fee schedules for medical care to the needy are in effect in all other states comparable in importance to Ohio; that in some states provision has been made for adjustable local fee schedules, as recommended by the Council of the Ohio State Medical Association on October 29; that some other states have recently increased their fee schedules; that in spite of the governmental policy in decreasing the value of the dollar and increasing wages and compensation and in spite of wages paid on governmental projects for all other types of services and labor, the medical profession in this state has received scant consideration by the State Administration or by local public officials in many communities.

We feel that the medical profession is justified in its disappointment and resentment especially when we view other governmental projects and activities calling for vast expenditures of public money for non-essentials.

Further lack of appreciation for scientific medicine and for the medical profession is evident by the failure on the part of the Governor to appoint a physician to the vacancy on the State Relief Commission; thus disregarding our official recommendation and the custom followed in many other states which have given such recognition to the importance of medical assistance and counsel in many medical questions involved.

The foregoing statement was adopted by the Council of the Ohio State Medical Association at its meeting on March 11, 1934, for submission to the component county medical societies and academies of medicine with the recommendation that they take official cognizance of the situation and factors summarized herein; that appropriate action be taken through resolutions or otherwise; that such action be communicated to Governor White, to local public officials charged with responsibilities for medical care to the needy, and to the Ohio State Medical Association; and that a concerted demand be made for adoption by Governor White and the State Relief Commission of the proper adjustment of the fee schedule as recommended by the Council of the Ohio State Medical Association on December 17, 1933.

Action of the Council in appealing to the membership direct for vigorous activity and concerted demand for proper adjustment in the temporary medical relief plan and unfair fee schedule followed months of forceful and constant activity on the part of the Council, the officers and committees of the State Association to have the fee schedule modified and increased.

REPEATED DEMANDS FOR REVISION MADE

Repeated requests had been made since last September by the officers and committees of the State Association for an official hearing with the State Relief Commission to discuss medical phases of the relief program and secure a modification and improvement of the fee schedule previously established by the Commission.

Official action on this and other questions relative to medical services to the needy was taken by the Council of the State Association as long ago as October 29, 1933, (pages 776 and 777 of the December, 1933, issue of *The Journal*). At a meeting of the Council on that date, an official statement was drafted and approved by the Council, making definite recommendations for a modification and improvement in the temporary plan and fee schedule. This statement and recommendations were officially transmitted to the State Relief Commission on October 30, 1933.

Before and after the Council meeting of October 29, numerous conferences were held by officers and committeemen of the State Association with individual members of the State Relief Commission and various departmental heads working under the Commission at which vigorous protests were made against the plan which had been promulgated and the inadequate fee schedule established. These conferences were augmented by much correspondence and many telephone calls to officials of the Commission asking a hearing before the Commission and requesting consideration of the recommendations made by the Council, but without success.

The Council of the State Association met again on December 17, 1933. At that time, the Council again took official action, requesting an adjustment and improvement in the fee schedule and made additional definite recommendations, inasmuch as no hearing before the Commission had been granted representatives of the State Medical Association and no action taken by the Commission on previous recommendations of the Council. The recommendations of the Council, taken December 17 (page 40, January, 1934, *Journal*) were transmitted officially to the Relief Commission on December 19.

CONFERENCE WITH GOVERNOR

On February 26, 1934, after repeated requests from officials of the State Association, a conference was secured with Governor White for the purpose of discussing with him the vital questions which

had arisen in the medical relief situation; protesting the lack of appreciation being shown for the unselfish services which had been and were being performed by the physicians of the state; convincing him of the need for modification and improvement in the medical relief plan and fee schedule, and conferring with him on other important state-wide questions of vital concern to the medical profession.

That conference was attended by Dr. C. L. Cummer, the President of the State Association; Dr. L. L. Bigelow, a former President of the State Association, representing Dr. C. W. Stone, chairman of the Committee on Public Policy, who was unavoidably prevented from being present, and Executive Secretary Martin.

Dr. Cummer, acting as spokesman for the representatives of the State Association, presented forceful arguments to the Governor for fair and adequate revison of the fee schedule; why the medical profession was entitled to greater consideration from the State Relief Commission, and the importance and advisability of appointing a physician, acceptable to the State Association, to the Relief Commission, which points and others had been previously stressed to officials of the Relief Commission.

SITUATION PRESENTED BY DR. CUMMER

In his presentation of the situation to the Governor (February 26), Dr. Cummer said:

"At the present time, the physicians of the state are extremely restless and greatly dissatisfied with the governmental attitude toward the profession. They feel that the government has not appreciated the importance of medical service and that it has not realized that the profession is closely organized to be of service to the government and to the public.

"For the past four years the doctors bore the brunt of medical work for the indigent population of the state, receiving for their services little or no compensation. Meanwhile all other purveyors of necessities—the butchers, the grocers and the clothing merchants—were receiving their pay. From time to time we officials were beset by inquiries as to why the doctors were not receiving some compensation, and we did our best to reassure the profession and on the other hand to secure some sort of compensation for them. Finally last September a fee schedule was promulgated. It was pathetic in its inadequacy, for the sums allowed for services were not sufficient to cover the overhead. Many protests were received, and they were exceedingly bitter in tone. Some of the county societies demanded of us emphatic action of some sort. For five months repeated efforts have been made by us to secure a readjustment of this fee schedule, which to date have been without results, and we are constantly in receipt of demands from our members for action.

"The situation has been made more acute by the fact that relatively higher fee schedules have been adopted in other states comparable in importance to Ohio, and by the fact that in spite of the economic distress among physicians with the urgent nature of medical care, the medical profession has received less adequate consideration than any other group affected by this prolonged economic situation.

"Not only are other purveyors of necessities being remunerated relatively well, but to make matters worse, relatively higher wages are being paid from governmental funds to skilled and even unskilled labor.

"After careful consideration in December last the governing body of our Medical Association requested a modification of the fee schedule, this proposal representing an average of no more than two-thirds of the fees ordinarily charged persons in moderate circumstances throughout Ohio.

"Other states have better fee schedules, and some have only recently increased their fees. The inadequacy of the fee schedule now in effect is accentuated by the decreased value of the dollar. The doctors are particularly perturbed by the fact that the policy of the NRA and of the governmental bureaus in general has been to maintain or to increase compensation generally, rather than to decrease it. Under the recent program, while the physicians are being told that money is not available for medical service, they at the same time see large funds being spent under the CWA for such things as art work in public buildings, paintings, statuary, civic operas and so on, which they feel is an injustice to them when they are providing an essential necessity.

"Furthermore, the situation will be complicated greatly upon the abandonment of the CWA, for this will return many individuals to the relief rolls for indefinite periods, increasing the burdens on physicians.

"The situation is greatly aggravated by the fact that in many communities even the present inadequate fees are not being paid at all, or at best only after long delay. which is contrary to the spirit of the Federal Regulations.

"Inasmuch as there is at the present time a vacancy on the State Relief Commission and since in many states there is at least one physician member of the relief commission, in Pennsylvania the chairman being a member of our profession, we wish to respectfully suggest that a physician acceptable to our organization be appointed to take the place recently vacated by Mr. Dudley Blossom.

In view of the demands of our members for information and action, and as the governing board of our State Association will meet within the next ten days, at which time plans must be made to accurately and fully inform our membership, I respectfully urge that this situation be promptly clarified and that your decision and that of the Relief Commission be communicated to us within the next few days, so that we in turn may inform our membership throughout the state of your attitude."

Dr. Bigelow and Executive Secretary Martin stressed other important problems in connection with medical services to the needy unemployed, to CWA workers disabled in the course of their employment, and medical problems of workmen's compensation, and reemphasized the statements made by Dr. Cummer to the Governor who at the conclusion of the conference promised to give the matters presented to him his prompt and serious consideration.

COUNCIL ACTS AND ISSUES STATEMENT

Up to the time of the meeting of the Council on March 11, 1934,—two weeks after the conference with Governor White—no action had been taken by the State Relief Commission in modifying or increasing the medical fee schedule, despite addi-

tional insistent requests from the officers of the State Association and many of the county medical societies for prompt adjustments in the schedule, and despite the fact that the state relief officials and the Governor's advisors had been notified that the Council was expecting definite information from the Commission on the question at its meeting on March 11.

Consequently, the Council adopted the foregoing statement and it was transmitted to the members of the State Association.

The principal *subsequent* development in the medical relief situation was the announcement by the State Relief Commission of adjustments and increases in the fee schedule, effective April 1, 1934.

SOLUTION OF CWA MEDICAL PROBLEMS SOUGHT BY THE COUNCIL AND OFFICERS

In addition to the vital problems which have arisen in connection with medical care of the needy, the officers, the Council and committees of the State Association have had to deal with serious questions pertaining to the plan of providing disabled Civil Works Administration employes with adequate medical, surgical and hospital care.

Since the advent of the Civil Works program last November, many conferences have been held by State Association officers and committeemen with officials of the State Civil Works Administration (which has the same personnel as the State Relief Commission) and officials of the state administration in an effort to preserve in so far as possible the choice by injured CWA employes of their own physicians; to obtain more prompt payment to physicians for services rendered, and to keep CWA officials properly informed on the medical phases of the CWA program.

The Council of the State Association (meeting March 11, 1934), realizing the importance of a sound policy toward medical practice and the medical profession on the part of the Civil Works Administration and local administrators and believing that concerted action by the county medical societies is necessary to insure proper administrative procedure in connection with medical services for injured CWA workers, adopted the following statement for submission to the county medical societies, which summarized some of the medical problems in the CWA plan:

CIVIL WORKS ADMINISTRATION MEDICAL PROBLEMS

In spite of the gradually liberalized federal policy to distribute, as far as practical, the opportunity of rendering medical service to injured employes under the Civil Works Administration, some local Civil Works administrators are insisting that this medical work be done by a small group of designated physicians. Some Civil Works administrators have failed to follow instructions issued by the federal and state Civil Works administrators to consult and cooperate with local county medical societies in formulating lists of physicians qualified and eligible to render such medical service at remuneration comparable to fees that could reasonably be expected from individuals in similar financial status in the same community.

In some communities centralized first aid stations are being established, either staffed by designated physicians or by nurses, requiring injured workmen to travel to centralized stations for first aid and treatment of minor injuries, rather than being treated by physicians more accessible at the time of injury.

There is unwarranted delay in compensation to physicians for services rendered to injured CWA workers after bills are rendered.

The foregoing statement was adopted by the Council of the Ohio State Medical Association on March 11, 1934, on recommendation of the Policy Committee, for submission to the county medical societies to develop a united and cooperative effort to correct or improve administrative procedure on CWA projects involving medical service.

FUTURE OF CWA UNCERTAIN

At the time this was written, there was considerable uncertainty as to future developments in the Civil Works Administration program. It is understood that the Civil Works program, as such, is to be abandoned and to be superseded by a new work-relief program, based on actual needs of those employed and set up on a geographical basis. Whatever plan of work-relief may be evolved, it is certain that some plan of providing injured relief workers with medical and surgical care will be necessary and may be patterned to a large extent after the plan established under the CWA program. For this reason, the officers and Council of the State Association are of the opinion that the membership should be adequately informed on this phase of the general relief program and should by vigorous activity and constant contact with their local administrators, support the activities of the State Association officers and committeemen in protecting the interests of the medical profession. Close contact and cooperation between representatives of county medical societies and local CWA or work-relief administrators will, in the opinion of the Council, go far toward correcting and improving the administrative procedure in providing injured relief workers with medical care.

At present definite rulings concerning the new work-relief program are lacking, especially that pertaining to the status of those who will be employed on work relief with respect to direct relief, including medical care. New problems in the medical aspects of the relief question may arise, calling for vigorous and concerted action on the part of the medical profession. For this reason it is vital that each county medical society keep in constant touch with its local relief director and keep itself informed on daily developments.

POSITIVE TENDENCIES AND PROGRAMS ARE UNDER WAY TO SOCIALIZE MEDICINE

Efforts to undermine organized medicine in its endeavors to function in behalf of the medical profession and to saddle the public with some type of socialized medicine that would exploit the medical profession and lower the existing standards of medical care have become more persistent during recent months.

Even before, but especially since, the Committee on the Costs of Medical Care made its reports, certain groups who harbor a determination to sovietize medical practice in this country have been attempting to incite rebellion within the ranks of the medical profession, belittle the value of medical organization, and break down the confidence of the public in the medical profession.

Leaders in this movement have been the executives and their aides of some of the larger philanthropic and social welfare organizations whose "master-minds" have become disgruntled over the lack of public interest in their socialized proposals and because medical organization has seen fit to oppose them.

Recent developments—several of which are the basis of the comments which follow—have given the medical profession definite proof as to the source of the campaign that has been directed at organized medicine and where to expect the strongest and most militant pressure for revolutionary changes in the present system of medical practice. It is important that the profession be advised of the attitude and intentions of these groups and individuals.

* * * *

Every physician should read the article published under the heading, Medical Economics, in the March 3, 1934, issue of *The Journal of the American Medical Association*, page 697.

It reports the addresses and discussions presented at a recent meeting in Philadelphia, arranged jointly by the American Academy of Political and Social Science and the Philadelphia College of Physicians.

The *A.M.A. Journal* editorially states that "although the program was planned originally to present the aspects of this topic (i.e., the relationship of the physician to the community) from various points of view, many members of the medical profession asserted that its chief purpose was to overwhelm the medical profession by pressure from without, leading toward the socialization of medical practice".

Among those who spoke were: Professor James S. Brossard, professor of sociology, University of Pennsylvania; Edgar Sydenstricker, director of research, Milbank Memorial Fund; Michael M. Davis, medical director, Julius Rosenwald Fund; William Trufant Foster, Newton, Mass., economist; Dr. Nathan B. Van Etten New York, vice speaker of the House of Delegates, A.M.A.; Dr. Morris Fishbein, editor of the *A.M.A. Journal;* Dr. Grant Fleming, McGill University professor; Dr. Roger I. Lee, Boston, and others.

Bossard, Sydenstricker, Davis and Foster suggested radical changes in the present system of providing medical care; questioned the right and ability of the medical profession to control itself, and made scathing attacks on the present leadership of the profession.

The viewpoint of medical organization was ably and courageously presented by Dr. Fishbein, Dr. Van Etten, and Dr. Lee, despite the atmosphere of hostility which charged the meeting.

Messrs. Sydenstricker, Davis and Foster, it will be remembered, were members of the Committee on the Costs of Medical Care. Davis and Foster were signers of the majority report. Sydenstricker submitted a solo report in which he showed resentment that neither the majority or first minority report had endorsed out-and-out state medicine. For this reason, their attack on medical organization came as no distinct surprise.

This Philadelphia meeting substantiated the belief which many physicians have had that certain individuals and groups have been and are waging an undercurrent campaign to undermine medical organization and incite discontent among its members. It established definitely that Davis, Sydenstricker, and others are committed to a program of vituperation, hoping to accomplish complete socialization of medicine by poisoning the public mind against the medical profession. It clearly indicated that the resources and influence of such agencies as the Rosenwald Fund, the Milbank Memorial Fund, the Twentieth Century Fund, etc., are available to those conducting this movement. It strengthens the suspicion that certain factions within the ranks of the medical profession have seen fit to give their support to these professional reformers.

Now that the attack on the medical profession and its organization from these sources has been thrown into the open, the medical profession as a group must make this decision:

Shall the physicians of the country look to the Rosenwald, Milbank, Twentieth Century funds, their executives, and other groups with similar views, for leadership in medical matters, or, shall they look to medical organization and able men within the ranks of the profession for this leadership?

Naturally, differences of opinion will arise within the ranks of the profession itself. However, this is now a matter of secondary concern. The big question confronting every physician is whether he is with medical organization in its endeavors to function at all times in behalf of the medical profession and the public or whether he is going to follow outsiders and permit them to run his affairs and shape the future of medical practice along lines that will be unsatisfactory to him and his patients.

* * * *

It is a well-known fact that the officials of the Milbank Memorial Fund were disappointed over the conclusions reached by the Costs of Medical Care Committee. After having contributed many thousands of dollars toward the activities of that committee, they were of the opinion that the committee might well have recommended state medicine as a solution to present-day medical-social problems, a theory supported by the Milbank organization.

Inasmuch as the majority report of the Committee on the Costs of Medical Care was a failure, in their opinion, the Milbank executives have launched a study of their own and will propose for public consideration "a plan of medical care for the American people, providing for more extensive prevention and treatment and more adequate payment for private physicians".

This undertaking was decided upon, as stated by John A. Kingsbury, secretary of the Milbank Fund in his annual report recently completed, "following the meager proposals offered by the Committee on the Costs of Medical Care to meet the deficiencies".

According to Mr. Kingsbury, the undertaking will be divided into three phases: (1) To summarize the deficiencies in medical care, with "a clear cut statement of the underlying problems"; (2) an appraisal of voluntary experiments in providing medical care for the United States, medical practice under workmen's compensation laws and the accumulated experience of health and sickness insurance in European countries; and (3) "an attempt to discover the principles and standards upon which state-wide programs might be based and the presentation of various kinds of action which may be undertaken according to local facilities for furnishing medical service and local abilities to pay the costs".

Mr. Kingsbury takes particular pains in his report to point out that "groups of physicians, dentists, nurses and other experts are assisting the Milbank staff and boards of counsel, which also include many physicians, in the task of outlining the proposed program.

The afore-mentioned Mr. Edgar Sydenstricker will be in charge of the work. He will be assisted by I. S. Falk, Ph.D., formerly associate director of study for the Committee on the Costs of Medical Care.

Inasmuch as Mr. Milbank will be generalissimo of this project and Messrs. Sydenstricker and Falk his chief lieutenants, one guess should be sufficient to predict the conclusions which they will arrive at and the type of "plan" they will recommend.

* * * *

One evidence of the "trend" is the following episode revealed in the columns of the *Indiana State Medical Journal* for March, 1934:

On February 1, 1934, Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, received a letter from the previously-mentioned, I. S. Falk of the Milbank staff. In his letter, Mr. Falk submitted a questionnaire on health and medical subjects, soliciting Mr. Hendricks' assistance and reminding him that "we are deeply interested in problems of medical economics and especially in the opinions of physicians and their professional associations in this field".

Whereupon, Mr. Hendricks took his pen in hand and wrote Mr. Falk as follows:

"The Indiana State Medical Association is actively interested in the ever-increasing number of medical economic problems and has gained the reputation of not only talking of these problems but of really attempting to do something definite and constructive about them.

"As your Mr. Kingsbury, without any real investigation or understanding, chose to attack the program of public health work that is undertaken in Indiana under the coordinated efforts of the State Medical Association, the State Medical School, and the State Division of Public Health, I do not feel that we care to answer your questionnaire as we have no assurance whatsoever that any report we may make will not be misunderstood and even perhaps misrepresented, in light of past performances by at least one of your spokesmen.

"From what we have seen of the public statements of Mr. Kingsbury we are of the opinion, regardless of facts, that your organization is committed to the socialization of medicine with all its evils, against which the medical organization of Indiana will continue to battle, both in the interests of the public and the profession. We feel that Mr. Kingsbury's action in timing his criticism of the new Indiana plan so it came during the meeting of the American Public Health Association here, and hence was arranged to embarrass the local public health officials and the medical profession of Indiana who were acting as hosts to that organization, was not good sportsmanship. Of course, it was difficult for anyone knowing the facts to understand how an officer of an organization so responsible to the public as is the Milbank Memorial Fund could make such a misstatement to the effect that Indiana had virtually given up all public health work.

"These are some of the reasons why we do not feel we should answer your questionnaire."

* * * *

The foregoing incidents are strong evidence as to which way the "wind blows".

CENTENNIAL CELEBRATION, MEDICAL COLLEGE, OHIO STATE UNIVERSITY, ATTRACTED LARGE ATTENDANCE AND CREATED WIDE INTEREST

Between 800 and 900 physicians attended the Centennial Celebration held in Columbus, March 1, 2 and 3, by the College of Medicine, Ohio State University.

Most of them, representing almost every community in Ohio and many other states, were graduates of the College of Medicine, or one of the earlier medical colleges whose continuous descent since the founding of Willoughby Medical College in 1834 has furnished Ohio with 100 years of interrupted medical education and laid the foundation of the present medical school at the state university.

In the opinion of many who attended sessions of the three-days reunion it was one of the finest post-graduate medical institutes ever held in this state and offered a scientific program of unusual merit, presented by some of the outstanding medical talent of the country. Officials of the university consider it one of the highpoints in the history of the school both from the standpoint of alumni interest and educational opportunities.

The splendid program, a masterpiece in many respects was arranged under the direction of the late Dr. Ernest Scott, head of the department of pathology, whose sudden and untimely death on March 5 has cast a shadow of sorrow on the end of the occasion and broke the ranks of those to whom credit was due for the success of the gathering.

An extensive and diversified program of clinics and laboratory demonstrations was presented on the morning and afternoon of the first day of the celebration. These were held at St. Francis Hospital, University Hospital, Children's Hospital, and Hamilton Hall and Kinsman Hall on the university campus. It was appropriate that one of the opening sessions of the gathering was held at St. Francis Hospital which for many years housed Starling Medical College, one of the predecessors of the present College of Medicine at the university.

The program at St. Francis Hospital consisted of clinics by members of the hospital staff, lectures by Dr. Bernard Nichols, Cleveland, and Dr. Gatewood, professor of surgery, Rush Medical College, Chicago, on "Developments in Roentgenology" and "Gastric Ulcer", respectively; and a lecture in costume by Dr. Francis Carter Wood, New York City, which was written in 1851 by Dr. Francis Carter, grandfather of Dr. Wood, and delivered at that time to the freshman class of Starling Medical College.

The clinics and lectures at University Hospital were given on the following subjects by members of the medical faculty of the College of Medicine:

Ileus—Dr. V. A. Dodd
Recent Advances, Treatment of Appendicitis—Dr. J. W. Means
Differential Diagnosis of Kidney Stone—Dr. W. N. Taylor
Hodgkins' Disease—Dr. H. L. Reinhart
Electrocardiography—Dr. G. I. Nelson
Pneumonia—Dr. S. A. Hatfield
Total Thyroidectomy for Heart Disease—Dr. George Curtis
Acute Hemoclastic Crisis in Hemolytic Icterus—Dr. C. A. Doan
Differential Diagnosis of Lymphadenopathy—Dr. B. K. Wiseman
Intranasal Oxygen—Dr. L. E. Barron
General Surgery—Dr. Dodd
Gynecology—Dr. Fred Fletcher and Dr. P. J. Reel
Urology—Dr. Taylor
General Surgery—Dr. Means
Thoracoplasty—Dr. Curtis

The presentations at Children's Hospital covered the following subjects, discussed by staff members:

Skull Injuries in Childhood—Dr. J. M. Dunn
Intraperitoneal Therapy—Dr. E. H. Baxter
Newly Observed Function of Inner Larynx—Dr. G. O. Russell
Bone Grafts as a Therapeutic Measure in Orthopedic Cases—Dr. E. H. Wilson
Pyelitis in Childhood—Dr. J. E. Hoberg
Hernia with Associated Ectopic Testis—Dr. H. E. Boucher
Management of Foreign Bodies in Lower Food and Respiratory Passages—Dr. H. G. Beatty
Squint in Childhood—Dr. A. D. Frost
Appendicitis Continues in Major Importance—Dr. L. L. Bigelow
Immunization in Infancy and Childhood—Dr. E. G. Horton

On Thursday afternoon, March 1, interesting laboratory experiments and lectures by members of the university faculty were presented at Hamilton and Kinsman halls on the campus, including such subjects as: Lectures in anatomy, demonstration of the freezing machine and frozen sections of the head, dissections, Aschheim-Zondek tests; activity experiments on rats, biologic assay of adrenalin, micro-respiration of living tissues, newer bacteriologic technics, *X*-ray exhibits of results of thoracoplasty, exhibition of drawings of cells from the supravital and from other technics, charts of case studies in various diseases now under clinical investigation, research in biochemistry, supravital study of living cells and other technics used in hematologic research, iodine metabolism, basal metabolism, demonstration of

high frequency short-wave length machine for inducing fever in animals, etc.

HISTORICAL DRAMA

Climaxing the Thursday afternoon program was the presentation at Hamilton Hall before a large audience of a series of skits, in costume, dramatizing the following historical medical events:

"The Anatomist—1538", students, College of Medicine.

"The Barber Surgeon—17th Century", students, College of Medicine.

"Lecture of Dr. Starling Loving to Class of 1856", Dr. L. L. Bigelow.

"Lecture of Dr. Francis Carter to Class of 1850-51". Dr. Francis Carter Wood, New York City, grandson of Dr. Carter.

"Wright Operation for Cataract—First Operation for Complete Removal of the Lens—1884", Dr. John W. Larcomb, grandson of Dr. John W. Wright.

"Gilliam Operation—1900", Dr. David B. Gilliam, grandson of Dr. D. Todd Gilliam.

The first general session of the celebration was held on Thursday evening, March 1, at University Hall, with Dr. J. H. J. Upham, dean of the College of Medicine, presiding. The following spoke: Dr. Francis Packard, editor, *Annals of Medical History*, Philadelphia, on "The Earliest Development of Organized Medical Education in This Country"; Dr. Jonathan Forman, Columbus, editor, *Phi Rho Sigma Bulletin*, on "The History of the College of Medicine", and Dr. George W. Rightmire, president, Ohio State University, on "The Place of Medical Education in the State University".

The highspots of the Friday morning convocation of the visiting alumni at University Hall were an address by Dr. Henry S. Houghton, associate dean, biological science, University of Chicago, on "The Challenge of the Future in Medical Education", and the awarding of the degree of honorary doctor of science to Dr. Houghton, Dr. Torald H. Sollman, Cleveland, dean of the School of Medicine, Western Reserve University, and Dr. William S. McCann, Rochester, N. Y., head of the department of medicine, Rochester University. The honorary awards were made by President Rightmire who presided at the convocation. Dr. Houghton and Dr. McCann are graduates of the College of Arts and Sciences, Ohio State University.

SCIENTIFIC ADDRESSES

A scientific program of unusual interest was presented Friday afternoon, March 2, by Dr. Francis Carter Wood, New York, and Dr. Edward Francis, Washington, D. C. Dr. Wood, editor of *The Journal of Cancer* and director of the Crocker Foundation for Cancer Research, spoke on phases of the cancer problem. Dr. Francis, a member of the staff of the United States Public Health Service, discussed "Tularemia", a subject on which he is credited with having made outstanding research contributions.

Medical and surgical clinics by some of the outstanding national figures in medicine were held on Saturday morning as follows:

Gastric Malignancy—Dr. Gatewood, Associate Professor of Surgery, Rush Medical College, Chicago, Ill.

Arterio-venous aneurisms—Dr. Mont Reid, Chairman, Department of Surgery, University of Cincinnati.

Surgery of the Esophagus—Dr. Roy D. McClure, Surgeon-in-Chief, Henry Ford Hospital, Detroit, Mich.

The Adrenal Problem—Dr. F. A. Hartman, Professor Physiology, University of Buffalo.

An Historical Review of the Use of Mercury in Syphilis—Dr. Torald Sollmann, Dean, College of Medicine, Western Reserve University, Cleveland, Ohio.

Edema and Nephritis—Dr. William S. McCann, Dewey Professor of Medicine and Physician-in-Chief, Strong Memorial and Rochester Municipal Hospitals, University of Rochester, Rochester, New York.

Irridiation Therapy—Dr. George T. Pack, Memorial Hospital, New York, N. Y.

Neurological Surgery—Dr. Robert Zollinger, Surgical Clinic, Peter Brent Brigham Hospital, Boston, Mass.

The Relationship of the Secondary Sexual Organs to the Testicular and Hypophyseal Hormones—Dr. Robert A. Moore, Associate Professor Pathology, Cornell Medical Center, New York, New York.

Pulsating Exophthalmos and Neurofibromatosis—Dr. Raymond L. Pfeiffer, Institute of Ophthalmology, Columbia Medical Center, New York, N. Y.

Cutaeous Lesions Accompanying Lymphoblastoma—Dr. Samuel T. Mercer, Research Fellow, Dept. Dermatology, Columbia Medical Center, New York, N. Y.

Closing session of the gathering was held on Saturday evening at which time the public Alpha Omega Alpha address was delivered by Dr. Charles P. Emerson, former dean of the College of Medicine, Indiana University, who spoke on "The East and the West—Contrast of the Effects of Cultures on the Diseases of Peoples or the Difference Between the Maladies of the Occident and Orient".

Incidental reunions and banquets by the various classes and fraternities added to the success and enjoyment of the celebration. Banquets were held by Phi Rho Sigma, Phi Chi, Alpha Kappa Kappa, Alpha Mu Pi, Theta Kappa Psi, Phi Delta Epsilon, and Alpha Epsilon Iota. Many of the classes held well-attended luncheon or dinner reunions during the three days.

INTERESTING EXHIBITS

Of unusual interest were the scientific and historical exhibits which included:

Pictorial History of College of Medicine
One Hundred Years of Medical Progress
Exhibits of old instruments and equipment
Display of Early Medical Books
Dr. Jonathan Forman's Display of Medical History, Franklin County, Ohio

The Physician's Office of 1850
Office of the Early Dentist
Museum of Pathology
Metabolism Room—Dr. Hitchcock, Ph.D. '26
Glomerular Nephritis
Pulmonary Tuberculosis—Dr. Stevenson
Rheumatic Endocarditis—Dr. Davidson, '33
Apparent Relationship of Chlorophyl and Hemoglobin—Mr. Delor, '34
View of Dental Clinic
Motion Picture, First Anesthetic Operation.

Official representatives of practically every medical school in the country and many colleges and universities not having medical schools were present at the celebration which attracted many of the laity and professions allied to medicine in addition to members of the medical profession. The Ohio State Medical Association was officially represented at the gathering by Dr. L. L. Bigelow, a former president of the State Association, appointed to serve in that capacity by Dr. C. L. Cummer, Cleveland, the President, who was unavoidably prevented from being present.

In commemoration of the celebration, a One Hundred Year Book will be issued in the near future. The volume, which will sell for $10, is now on the press. It will contain a complete report of the three-days celebration and historical data concerning the present medical college and the earlier schools which preceded it. The book will be dedicated to Dr. Scott. Orders for the book are being received by the Secretary, College of Medicine, Ohio State University.

—O S M J—

A Fantastic Apparatus

Physicians who have not already done so will enjoy in the January 6, 1934, issue of *The Journal of the American Medical Association*, pages 61-65, an expose by the Bureau of Investigation of the A. M. A. of "a fantastic piece of pseudo-medical apparatus" known as the "Micro-Dynameter", invented by an F. C. Ellis, who calls himself a consulting engineer, and marketed by the Ellis Research Laboratories, Inc.

Referring to the micro-dynameter and the micro-dynamics theory as "essentially a further extension of the preposterous theories of Albert Abrams . . . the most polished charlatan of the century", the A. M. A. Bureau added:

"The peculiar theories and still more peculiar device of Mr. Ellis would probably never have become of sufficient importance to warrant a detailed description of them had it not been for the fact that Mr. Ellis' device has been given a quasi-respectability by having been exhibited at the convention of the Inter-State Postgraduate Medical Assembly at Cleveland".

Ohio physicians who attended that convention in Cleveland and who perchance saw the micro-dynameter on exhibition will be especially interested in reading what the Bureau of Investigation investigators have to say about this unique machine "which reduces the diagnosis and treatment of disease to the simplicity of a nickel-in-the-slot gum-vending machine".

—O S M J—

Ruling on T. B. Hospital Trustee Status

A physician who is a trustee of a District Tuberculosis Hospital may not be appointed by the board of trustees to serve as consulting surgeon of such hospital, according to a recent opinion of Attorney General John W. Bricker.

As stated in the opinion, "it is against the settled public policy of this state to allow an appointing officer or members of an appointing body to appoint a member of that body for the performance of personal or professional services". Mr. Bricker amplified this statement by declaring that "such has always been uniformly recognized as the rule obtaining in Ohio, unless the General Assembly gives its expressed consent to such appointments". Under the statutes governing district tuberculosis hospitals, no consent to such an appointment is given, the opinion stated.

—O S M J—

Attendance at the classes for prospective mothers who are patients of the Cleveland Academy of Medicine members totaled 1017 during 1933. The classes which are under the direction of Mrs. Ellen N. Nicely, R. N., consist of private patients of Academy members who are referred to the classes by their physicians.

—O S M J—

Under the direction of an Advisory Committee of the Cleveland Academy of Medicine, the Association for the Crippled and Disabled is offering its services to Cleveland hospitals and other institutions in furtherance of occupational therapy for cardiac, tubercular and orthopedic cases.

—O S M J—

The 1933 Nobel prize for medicine has been awarded to Dr. Thomas Hunt Morgan, Pasadena, California, in recognition of his discoveries concerning the eugenic functions of chromosomes and genes.

—O S M J—

Intravenous injection of trypan blue dye have been found to be an effective method of treating a considerable number of leprosy, according to an announcement by Dr. Victor G. Heiser, Far East director of the Rockefeller Foundation.

—O S M J—

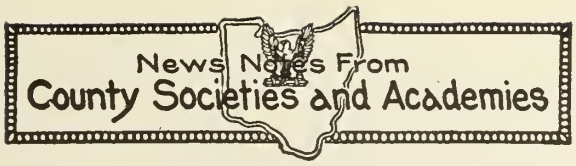
Statisticians of the Metropolitan Life Insurance Company have found that almost an entire year was added to the general average duration of life, during the decade 1920 to 1930.

—O S M J—

Sixty-third Annual Meeting of the American Public Health Association will be held in Pasadena, Calif., September 3-6, 1934.

—O S M J—

Annual meeting of the National Tuberculosis Association will be held in Cincinnati, May 14-17, 1934. The Netherland Plaza will be the headquarters hotel.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(Harold F. Downing, M. D., Secretary)

March 5—General Session. Program: "The Physiology of Youth", Dr. T. Wingate Todd, professor of anatomy, Western Reserve University, School of Medicine.

March 12—General Session. Program: "Fractures of the Femur in Children", Dr. John A. Caldwell; discussion by Dr. Joseph A. Freiberg and Dr. Ralph G. Carothers. "Some Problems in Compound Fractures", Dr. Ralph G. Carothers; discussion by Dr. Louis Feid, Jr.

March 19—General Session. Program: "The Role of Fluids in Surgery", Dr. Joseph D. Heiman; discussion by Dr. H. H. Shook and Dr. Clyde S. Roof. "Carbuncle of the Kidney", Dr. E. O. Swartz; discussion by Dr. H. B. Freiberg and Dr. R. W. Staley.

March 26—General Session. Program: "Water Metabolism—Its Relation to Weight Variations", Dr. Robert C. Rothenberg; discussion by Dr. Cecil Striker and Dr. Stanley E. Dorst. "Milk That Is Available in Cincinnati", Dr. Benjamin Hoyer; discussion by Dr. J. H. Batsche.

A resolution protesting the attitude of the State Relief Commission toward the suggestions and recommendations of the State Association in matters of medical service to the indigent sick and voicing disapproval of the failure by the Governor to appoint a physician to the commission has been adopted by the Academy and a copy of the resolution sent to the Governor.

Clinton County Medical Society in regular session March 6 at Wilmington adopted unanimously a resolution deploring the attitude of the State Relief Commission toward the medical profession in ignoring the suggestions and recommendations of medical organization on questions of medical service to the needy sick; protesting the appointment of an osteopath to the State Relief Commission, and requesting the cooperation of medical organization be sought in connection with the investigation of the workmen's compensation system.—Dalton E. Peelle, M.D., secretary.

Highland County Medical Society met on February 7 at the Parker House, Hillsboro, and following a luncheon was addressed by Dr. Ralph Carothers, Cincinnati.—News Clipping.

Warren County Medical Society has installed the following officers for the ensuing year: President, Dr. P. W. Tetrick, Mason; vice president, Dr. Russell Brewer, Lebanon; secretary, Dr. James H. Arnold, Lebanon; treasurer, Dr. Mary Cook, Waynesville; legislative committeeman, Dr. S. S. Stahl, Franklin; medical defense committeeman, Dr. N. A. Hamilton, Franklin; delegate, Dr. Hamilton; alternate, Dr. L. Mounts, Morrow.—James H. Arnold, M.D., secretary.

Second District

Champaign County Medical Society was addressed by Dr. Robert C. Austin, Dayton, at its meeting February 15 at Urbana. Dr. Austin discussed "Intestinal Obstruction".—News Clipping.

At its meeting March 9, the society was addressed by Dr. W. A. Stoutenborough, Columbus, who talked on "Strabismus in Children".—Bulletin.

Greene County Medical Society at its regular meeting March 1 was addressed by Dr. W. B. Taggart, Dayton. Dr. Taggart spoke on "Convulsions in Childhood". The paper was of great interest and well received.

Upon authorization of the society, a statement was prepared by the Board of Censors and communicated to Governor White, objecting to the present medical fee schedule for services to the indigent sick; condemning the failure of the State Relief Commission to cooperate with medical organization on medical matters, and protesting the appointment of a non-medical member to the Relief Commission.—Harold E. Ray, M.D., secretary.

Miami County Medical Society met on March 9 at the Memorial Hospital, Piqua. Dr. Warren Coleman presented a paper on "The History of the Miami County Medical Society". At the business session the society discussed plans for the establishment of a medical credit bureau. Problems in connection with medical service under the emergency relief set-up were considered. After discussion, the society authorized preparation of a statement to be communicated to the Governor protesting the appointment by him of a member on the State Relief Commission and condemning the unsympathetic attitude of the commission toward questions of vital concern to the medical profession. The society approved of the recommendations made by the Council of the State Association for adjustment of the inadequate medical fee schedule promulgated by the Relief Commission.—G. A. Woodhouse, M.D., secretary.

Montgomery County Medical Society was addressed on March 2 by Dr. G. Wayne Brehm, Columbus, on the subject, "Home Deliveries and

Ante Partum Care". The paper was discussed by Dr. Clagett and Dr. Gilfillen.

A special called meeting of the society was held on March 6 when resolutions were adopted condemning the failure of the State Relief Commission and State Administration to give due consideration to the medical profession in connection with care of the poor and to the suggestions of medical organization on matters of medical service; requesting an increase in the fee schedule for medical care of the indigent as suggested by the Council of the State Medical Association, and protesting the failure of the Governor to appoint a physician to the Relief Commission. By order of the society, the secretary was instructed to send copies of the resolutions to Governor White.

On March 16, the society was entertained at the Dayton State Hospital. Following a complimentary dinner, the hospital staff presented a scientific program.—Bulletin.

Third District

Allen County — The Academy of Medicine of Lima and Allen County at a special called meeting on March 4 adopted a resolution protesting the lack of consideration given to the medical profession by the State Relief Commission and advocating a more equitable schedule of fees for medical services for the needy sick.—K. L. Parent, M.D., secretary.

Auglaize County Medical Society met in regular session February 15 at St. Marys with an attendance of eighteen. Dr. E. H. Hedges, Lima, was the guest speaker. He presented a paper on "Treatment of Prostatic Hypertrophy", in which he emphasized transurethral cautery punch and supra-pubic prostatectomy, according to the pathological conditions present. Dr. J. R. Tillotson, Lima, and Dr. H. S. Noble, St. Marys, and Dr. C. C. Berlin, Wapakoneta, reported their experiences in their week's visitation at the Johns Hopkins Hospital, Baltimore, with members of the Physicians Travel Club, Lima. Dr. C. L. Baker, Cridersville, and Dr. T. H. Will, Minster, were admitted to membership.

By special action, the society authorized the president and secretary to communicate with Governor White on behalf of the Society, requesting him to support the recommendations of the Council of the State Medical Association on matters of medical service to the needy poor and develop a more sympathetic attitude toward the medical profession by the State Relief Commission.—C. C. Berlin, M.D., Secretary.

Hancock County Medical Society held its regular meeting March 1 at the Elks' Club, Findlay. Dr. Robert Benner, Tiffin, presented an interesting paper on "Latest Developments in the Treatment of Cancer with Ether and Chloroform Narcosis". A general discussion followed the paper. The society voted unanimously to send a letter of protest to the Governor relative to his failure to appoint a physician on the State Relief Commission and the handling of medical matters in connection with poor relief.—H. O. Crosby, M.D., secretary.

Hardin County Medical Society met February 15 at Kenton at which time a symposium on cardio-renal diseases was presented.—News Clipping.

Marion County—The Academy of Medicine of Marion was addressed on March 6 by Dr. William Mithoefer, Cincinnati, on "Sinus Diseases".—News Clipping.

Van Wert County Medical Society at its meeting February 6 was entertained with a symposium on "The Traumatic Patient—Medical, Legal and Financial Aspects", presented by Dr. D. F. Russell, Dr. F. W. Dannecker and Dr. W. E. Beach.—Bulletin.

On March 6, the subject, "The Challenge of Modern Obstetrics" was discussed by Dr. C. G. Church, Dr. J. R. Jarvis and Dr. L. Irwin.

Officers of the society were authorized to draft and send to the Governor a statement protesting his failure to appoint a physician on the State Relief Commission and asking for greater consideration for the medical profession in poor relief matters.—Bulletin.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M. D., Secretary)

March 2—General Session. Program: "Professional Participation in Public Health Work", Dr. Henry F. Vaughn, commissioner of health, Detroit.

March 9—Section of Pathology, Experimental Medicine and Bacteriology. Program: "The Pathology of Bone Tumors", Dr. Plinn F. Morse, Detroit; "Roentgenological Diagnosis of Bone Tumors", Dr. John T. Murphy; discussants, Drs. A. H. Schade, M. E. Goodrich, T. L. Ramsey, Harry Dachtler and B. G. Chollett.

March 16—Medical Section. Program: "What Are the Psychoneuroses", Dr. Carl D. Camp, professor of neurology, University of Michigan.

March 23—Surgical Section. Program: "Fetal Mortality", Dr. D. S. Booth; "An Analysis of the Causes of Maternal Mortality", Dr. M. W. Diethelm; discussants, Dr. M. D. Haag and Dr. R. C. King.

Sandusky County Medical Society in session February 22 at Fremont was addressed by Dr. E. G. Galbraith, Dr. T. W. Durbin and Dr. William A. Neill, all of Toledo. They discussed "Respiratory Infections".—News Clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M. D., Secretary)

March 2—Clinical and Pathological Section. Program: "Compound Fractures—Conservative Treatment", Dr. W. G. Stern; "Osteogenesis Imperfecta", Dr. J. W. Epstein; "Granulosa Cell Tumor of Ovary", Dr. J. Wolfstein and Dr. B. Kline; "Gastric Resection—End Results After Five Years", Dr. M. E. Blahd; "Branchiogenic Cyst", Dr. H. Gans; "Amoebic Dysentery", Dr. S. S. Berger; "Traumatic Intracranial Arterio-Venous Aneurysm", Dr. M. Friedman; "Implantation of Biliary Fistula Into Stomach", Dr. A. Strauss; "Tumors of the Bony Pelvis", Dr. H. A. Mahrer.

March 9—Joint meeting of Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program: "Relation of Occupation to the Ratio of Male and Female Death Rates From Pneumonia", Dr. J. A. Doull and Ben Fisher, A.B.; "Attempts to Dissociate Dick-Toxin-Producing Strains of Streptococcus", Dr. E. Megrail and R. L. Thompson, D.Sc.; "Seasonal Distribution of Measles, Scarlet Fever and Diphtheria for Periods of High and of Low Incidence", Dr. G. E. Harmon and Sarah M. Hindman, A.B.; "Antitoxic Content of Human Blood in the Tropics and Its Significance", Dr. R. C. Hahn; "Can Deaths from Puerperal Septicemia Be Reduced?" Dr. G. E. Harmon; "Leprosy on Mactan", Dr. J. A. Doull.

March 16—General Session. Program: "Some Practical Problems in the Handling of Peripheral Arterial Disease"; Dr. W. J. Merle Scott and Dr. John Morton, professors of surgery, University of Rochester Medical School.

Erie County Medical Society has installed the following officers for the ensuing year: President, Dr. Julius C. Kramer, Sandusky; vice president, Dr. R. E. Garnhart, Milan; secretary-treasurer, Dr. George A. Stimson, Sandusky; legislative committeeman, Dr. C. E. Swanbeck, Huron; delegate, Dr. F. M. Houghtaling, Sandusky; alternate, Dr. H. W. Lehrer, Sandusky.—George A. Stimson, M.D., secretary.

Huron County Medical Society held a well-attended meeting February 13 at Norwalk. Dr. F. E. Jones, Cleveland, was the guest speaker. He discussed "Malignancies and Their Treatment". Cases of cancer of the face and neck before and after treatment were shown by lantern slides.—P. C. Pilkey, M.D., correspondent.

Lake County Medical Society was addressed by Dr. C. L. Hartsock, Cleveland, at its meeting February 27 at Painesville. Dr. Hartsock discussed "The Irritable Colon".—Mabel L. Pearce, M.D., secretary.

Lorain County Medical Society met at the Elyria Memorial Hospital, March 15. Following a dinner, Dr. A. J. Skeel, Cleveland, the guest speaker, discussed "The New York Academy Report on Obstetric Mortalities in New York". Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, was present and discussed with the society economic and organization questions.—Bulletin.

Trumbull County Medical Society was addressed on February 15 by Dr. C. W. McGavran, Columbus, on "The 1934 Diabetic Problem". The public was invited to the meeting which was held in the Y.W.C.A. auditorium and was sponsored jointly by the medical society and the Health Education Department of the Y.W.C.A.—News Clipping.

Sixth District

Ashland County Medical Society at its regular meeting on February 16 was addressed by Dr. C. B. Meuser, Ashland, on "Child Welfare As Outlined at the Hoover Conference in 1930". A chicken dinner was served at the First Congregational Church before the program.

At a called meeting on February 23, the society voted not to endorse or sign as a society the contract sent to the society by the county relief administrator for furnishing medical care to those on the poor relief rolls under the regulations promulgated by the State Relief Commission.

Further discussion of the medical relief question was held by the society on March 9 at which time a resolution was adopted, protesting the failure of the Governor to appoint a physician on the State Relief Commission and condemning the unsympathetic attitude of the commission toward problems of furnishing medical care to the needy sick.—M. J. Thomas, M.D., secretary.

Holmes County Medical Society met on February 7 to discuss local problems in connection with furnishing medical care to the needy sick. Arthur Uhl, county relief administrator, was present and discussed the local relief situation.—News Clipping.

Mahoning County Medical Society was addressed on March 20 by Dr. William E. Lower and Dr. William J. Engel, both of Cleveland. Dr. Lower discussed "Endocrine Factors in Human Economy", and Dr. Engel spoke on "The Present Status of Intra-Vesical Surgery".—Bulletin.

Portage County Medical Society met March 1 at the office of Dr. J. H. Krape, Kent. Dr. Carl Steinke and Dr. H. V. Sharp, both of Akron, addressed the society, the former on "Empyema, Acute and Chronic" and the latter on "The New Anesthesias". At its business session, the society adopted resolutions endorsing the recommendations of the Council of the State Medical Association relative to medical questions arising in administration of the emergency relief system; requesting the free choice of physician in medical services for injured C.W.A. workers, and asking that the cooperation of medical organization be

requested in the impending workmen's compensation investigation.—E. J. Widdecombe, M.D., secretary.

Stark County Medical Society met February 13 at the Canton Elks' Club. The following program was presented: "Infant Feeding", Dr. Fred King; "Immunization Against Various Contagious Diseases", Dr. Pauline Zinninger; "The Use of Serum in the Treatment of Pneumonia", Dr. A. V. Fisher; "Disorders of the Thymus Gland", Dr. Frankman; "Review of Vitamin Deficiency in Infancy and Childhood", Dr. Ray Schirack. Dr. L. A. Buchman, the president, announced the appointment of the following committees: Policy committee, Drs. Wylie Scott, chairman, C. A. Lamont, L. L. Lawrence and O. W. Show; medical defense, Drs. J. H. Holston, chairman, George Zinninger, Perry King, E. O. Morrow, H. M. Schuffell, E. J. March and Emerson Gillespie; legislative, Dr. J. M. VanDyke.—H. W. Beck, M.D., secretary.

Summit County Medical Society met March 6 at the Mayflower Hotel. The guest speaker was Dr. John Dickenson, Cleveland, who spoke on "Cranial Cerebral Injuries".—Bulletin.

Seventh District

Belmont County Medical Society in session March 8 unanimously adopted resolutions and a statement to Governor White requesting prompt action by the State Administration and State Relief Commission in revision of the fee schedule for medical services to those on relief rolls as recommended by the Council of the State Medical Association; asking preservation of the free choice of physician in all relief and C.W.A. activities, and protesting and condemning the unsympathetic attitude of the Relief Commission toward the medical profession.—C. W. Kirkland, M.D., secretary.

Tuscarawas County Medical Society had as its guest speaker on March 8 Dr. Joseph Barrach, Pittsburgh, who addressed the society on "Modern Treatment of Diabetes". Dinner was served preceding the program.—Bulletin.

Eighth District

Guernsey County Medical Society met February 15 at the Berwick Hotel for luncheon, after which Dr. C. F. Shively, Cambridge, presented an interesting paper on "Enuresis".

On March 1 the society was entertained by the Wells Hospital. Dinner was served the members and their wives. Memoirs of their early experiences in practice were presented by several members and a social time enjoyed.—O. R. Jones, M.D., correspondent.

Licking County Medical Society met February 23 at the Newark City Hospital. The guest speaker was Dr. George Sims, Columbus, who discussed "Radiation Therapy".—Bulletin.

Perry County Medical Society held its regular meeting February 19 at the Park Hotel, New Lexington. Dr. Vosper, Crooksville, was the principal speaker, discussing "Focal infections of the Mouth Producing Systematic Conditions".—News Clipping.

Washington County Medical Society at a special meeting in Marietta adopted unanimously a statement to be sent to Governor White condemning his appointment of an osteopath to the State Relief Commission and protesting the lack of cooperation of the State Administration with the medical profession on matters in connection with medical service to the needy sick.—G. M. James, M.D., Secretary.

Ninth District

Lawrence County Medical Society in session March 1 unanimously adopted a statement to be sent to Governor White regretting his failure to appoint a physician to the State Relief Commission and expressing regret at the lack of consideration given the medical profession in the handling of the poor relief situation; and, further, requesting that the advice and counsel of medical organization be sought in connection with the workmen's compensation investigation.—Anne D. Marting, M.D., Secretary.

Meigs County Medical Society devoted its meeting of February 15 to a discussion of questions in connection with medical service to the needy sick. The matter of medical fees as established by the State Relief Commission was discussed with the county relief administrator. The society went on record as opposing the present fee schedule and approving of the schedule recommended by the Council of the State Medical Association.—R. E. Boice, M.D., secretary.

Pike County Medical Society met March 6 at the Emmitt House, Waverly. Following dinner, questions of medical relief to the poor were discussed. It was announced that the society had a 100 per cent membership record.—Robert T. Leever, M.D., secretary.

Scioto County—The Hempstead Academy of Medicine met March 12 at the Nurses' Recreational Hall. The program was presented by Dr. C. M. Fitch who spoke on "The Effectiveness of Mercury as a Diuretic". Supper was served following the meeting.—Bulletin.

By special action of the Academy, a telegram from the Academy was sent to Governor White condemning his refusal to appoint a physician acceptable to medical organization on the State Relief Commission.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M. D., Secretary)
(George J. Heer, M. D., Secretary Pro-Tem)

March 5—General Session. Program: "Disruption of Abdominal Wound", Dr. J. F. Baldwin;

discussants, Drs. J. Mitchell Dunn, Joseph Price, William P. Smith and I. B. Harris.

March 12—General Session. Program: "Clinical Consideration of Goiter, Dr. R. A. Ramsey; "Metabolism and Hypothyroidism", Dr. F. W. Gosnell; "Inflammation and Malignancy", Dr. J. E. Briggs. Discussion led by Dr. Andre Crotti.

March 19—General Session. Program: "Bleeding at the Menopause", Dr. H. H. Yoakem and Dr. George P. Sims; discussants, Drs. H. L. Reinhart, P. J. Reel and E. T. Kirkendall.

March 26—General Practitioners' Section. Program: "A New(er) Treatment of Colitis", Dr. Anton W. Oelgoetz.

Knox County Medical Society was addressed on February 22 by Dr. J. E. Brown, Jr., Columbus. —News Clipping.



OHIO DEATHS

Adam Borman, M.D., Toledo; Medical College of Ohio, Cincinnati, 1881; aged 71; died February 8 of burns. Dr. Borman had practiced in Glandorf, Delphos and New Riegel for many years before moving to Toledo. He retired two years ago following a stroke of paralysis. He leaves his widow, one daughter, three sisters and three brothers.

Osear O. Blakeslee, M.D., Conneaut; College of Physicians and Surgeons, Baltimore, 1882; aged 80; died February 28 of pneumonia. Dr. Blakeslee was health commissioner of Conneaut and had practiced there for many years.

John Newton Calhoun, M.D., Lisbon; Western Reserve University, School of Medicine, 1876; aged 80; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 11 of pneumonia. Dr. Calhoun practiced at Elkton before locating in Lisbon in 1889. He was a charter member of the Columbiana County Society and a member of the Methodist Episcopal Church, the Odd Fellows and Knights of Pythias lodges. Surviving are his widow and one daughter.

John S. Gallagher, M.D., Salem; Western Reserve University, School of Medicine, 1887; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died February 20 of heart disease. Dr. Gallagher had practiced in Salem for the past 27 years, moving there from Macedonia about 1907. He was a member of the Methodist Church and Elks and Eagles lodges. His widow, two sons and two daughters survive.

George E. Gerken, M.D., Toledo; University of Michigan, School of Medicine, 1921; aged 38; former member of the Ohio State Medical Association and the American Medical Association; died February 26 of peritonitis. Dr. Gerken was physician at the Lucas County jail. He belonged to the Knights of Columbus and Foresters' lodges. Surviving are his widow, two sons and one daughter.

Mauriee P. Jones, M.D., Youngstown; University of Michigan, School of Medicine, 1907; aged 50; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 13 of heart disease. Dr. Jones, a member of the American College of Surgeons, was a World War veteran and a former president of the Mahoning County Medical Society. At the time of his death he was chief of the surgical department at the Youngstown City Hospital. He belonged to the Elks' Lodge. Surviving are his widow, one son, one brother and two sisters.

William R. Keller, M.D., Dover; Hahnemann Medical College and Hospital, Philadelphia, 1910; aged 47; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 14 of heart disease. Dr. Keller located in Dover in 1916. He was a World War veteran and a member of the Elks' Lodge, Kiwanis Club and the Moravian Church. His widow, one son, his mother and two brothers survive.

Allen F. Latta, M.D., Cumberland; Louisville Medical College, Louisville, Ky., 1895; aged 60; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 22 of heart disease. Dr. Latta, a native of Monroe County, had practiced in Cumberland for the past 18 years. Surviving are one son, Dr. Heber Latta, Graysville; two brothers and two sisters.

John M. Leslie, M.D., Greenfield; Medical College of Ohio, Cincinnati, 1876; aged 84; member of the Ohio State Medical Association and the American Medical Association; died February 20 of infirmities of age. Dr. Leslie was born near Greenfield but practiced for many years at Chillicothe, retiring to his old home near Greenfield recently. In 1920, Dr. Leslie was honored at a

dinner given by the Ross County Medical Society celebrating his 50th anniversary in active medical practice. One sister survives.

Roger S. Morris, M.D., Cincinnati; University of Michigan, School of Medicine, 1902; aged 57; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 1 following an extended illness. Dr. Morris, head of the Medical Department, University of Cincinnati, suffered a nervous breakdown several months ago. Before taking charge of the Medical Department, University of Cincinnati, 18 years ago, Dr. Morris had served on the faculty of medicine, University of Michigan; as head of the Clifty Springs Sanitarium, Clifty Springs, N. Y., and professor of medicine at Washington University, St. Louis and Johns Hopkins University. He had gained national fame for his research work in diseases of the blood. During the World War, he served overseas. Dr. Morris was a member of the American College of Physicians, Association of American Physicians, American Society for Clinical Investigation, Psi Upsilon and Nu Sigma Nu fraternities and the Cincinnati Country Club, and was director of the medical services at the Cincinnati General Hospital and on the staff of the Holmes Hospital. Surviving are his widow, one son, his mother and one sister.

Galen E. Moyer, M.D., Elyria; University of Pittsburgh, School of Medicine, 1917; aged 46; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 3 of diabetes. Dr. Moyer had lived in Elyria for the past 14 years. He served as a navy surgeon during the World War. Dr. Moyer was a member of the Masonic and Elks lodges, the Episcopal Church, and the Veterans of Foreign Wars. His widow, three sisters and one brother survive.

John D. O'Gara, M.D., Urbana; Starling Medical College, Columbus, 1903; aged 54; member of the Ohio State Medical Association and the American Medical Association; died February 18 following an operation for gall stones. Dr. O'Gara was a native of Urbana and had practiced there since his graduation from medical school. At the time of his death, Dr. O'Gara was president of the Champaign County Medical Society. He was a member of the Knights of Columbus and the Foresters Lodge. Two sisters and three brothers survive.

George L. Pearson, M.D., Youngstown; University of Pittsburgh, School of Medicine, 1897; aged 65; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 11. Dr. Pearson was a native of Pittsburgh and had practiced in Youngstown for the past 35 years. He was a Fellow of the American College of Physicians and at the time of his death was medical director for the Truscon Steel Company. His widow, one daughter and one brother survive.

Ernest Scott, M.D., Columbus; Ohio Medical University, Columbus, 1900; aged 59; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 5 of coronary thrombosis. Dr. Scott was professor of medicine, chairman of the department of pathology, and secretary of the College of Medicine, Ohio State University. He was a member of the American Association of Pathologists and Bacteriologists and the American Society of Clinical Pathologists, and was one of the foremost pathologists and bacteriologists in the Middle West. He was bacteriologist for the Columbus Health Department, Columbus State Hospital and the University Hospital. On March 1, 2 and 3, Dr. Scott served as general chairman of the program presented at the Centennial Celebration held by the College of Medicine, Ohio State University. He is survived by his widow, two daughters, his father, William Henry Scott, only living ex-president of Ohio State University, two brothers and two sisters.

LaMont B. Smith, M.D., Youngstown; Cleveland Pulte Medical College, 1898; aged 59; died February 12. Dr. Smith had practiced in Youngstown for the past 30 years. He leaves his widow, one daughter, two sons, his mother and two brothers.

Charles Clifford True, M.D., Port Clinton; Cleveland University of Medicine and Surgery, 1884; aged 84; died February 12. Dr. True had practiced in Cleveland for more than 40 years, moving to Port Clinton, where he had resided as a youth, in 1922. He was a member of the Masonic Lodge. His widow survives.

Elmer E. Vorhies, M.D., Cambridge; Starling Medical College, 1893; aged 69; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 11 of acute dilation of the heart. Dr. Vorhies had practiced in Cambridge for 40 years and was surgeon for several industrial firms in Guernsey County. He belonged to the Methodist Episcopal Church and the Masonic, Eagles, Moose and Red Men lodges. Dr. Vorhies served several terms as coroner and was a former member of the Ohio Senate. His widow, two sons, one of whom is Dr. Clyde L. Vorhies, Cambridge and one daughter survive.

William L. West, M.D., New Matamoras; Jefferson Medical College, Philadelphia, 1874; aged 84; former member of the Ohio State Medical Association and the American Medical Association; died February 21 of pneumonia. He had practiced in New Matamoras since graduating from medical school. Dr. West was a captain in the Spanish-American War and served in the

Medical Corps during the World War. He was a former mayor of New Matamoras and former member of the village council and board of education, and was active in Masonic affairs. His widow and one daughter survive.

KNOWN IN OHIO

John William Adair, M.D., Kenosha, Wisconsin; Cleveland University of Medicine and Surgery, 1887; aged 70; died February 15. Dr. Adair formerly resided in Marion where he was on the staff of the Sawyer Sanatorium. His widow and one brother survive.

Winfred M. Johnson, M.D., Johnson Creek, Wisconsin; Ohio Medical University, Columbus, 1898; aged 63; a Fellow of the American Medical Association; died February 13. Dr. Johnson was a native of Hancock County and practiced medicine in Findlay before moving to Wisconsin. His widow, two daughters and three brothers survive.

NEWS NOTES of OHIO

Cleveland—Members of the faculty of the School of Medicine, Western Reserve University, gave a surprise luncheon February 10 at the Cleveland Club, honoring Dr. Torald Sollman, dean of the school, on his 60th birthday. In memory of the occasion, Dr. Sollman was presented a decorated parchment manuscript felicitating him and congratulating him on his scientific achievements and record as head of the school.

Portsmouth—Dr. A. R. Moore has been named city physician succeeding Dr. J. P. McAfee, resigned.

Cleveland—Dr. Frank P. Corrigan has been appointed United States minister to Salvador.

Dayton—Dr. Robert C. Markey, graduate of Cornell, who recently completed his internship at Grasland Hospital, N. Y., has joined his father, Dr. Edward B. Markey, in private practice.

Chillicothe—More than 150 persons attended the informal reception for Dr. Dennis J. Murphy, new superior medical officer at the Chillicothe Veterans' Hospital.

Springfield—Dr. Charles A. Doan, Columbus, addressed the local Rotary Club on "The Romance of Medical Research".

Hillsboro—Dr. Clifford Foor, who recently completed a three-year course at the Mayo Clinic, has opened offices here.

Norwood—Dr. John S. Meserve was badly injured in a recent automobile accident.

Cincinnati—Dr. R. Sidney Cunningham, School of Medicine, Vanderbilt University, delivered the fourth annual series of pediatric lectures under the Benjamin Knox Rachford lectureship at the University of Cincinnati.

South Vienna—Dr. E. H. Long, a lieutenant in the medical reserve corps, is taking special work at Randolph Field, San Antonio, Texas.

Youngstown—Dr. Stanley Myers, resident physician, Youngstown Hospital, will start a six months' appointment in surgery at the New York Memorial Hospital on July 1.

Cleveland—Dr. Myron Metzenbaum recently addressed the biological department, Western Reserve, on "The Evolution and Function of the Nasal Septum in Man".

Youngstown—Dr. R. B. Poling, pathologist at St. Elizabeth's Hospital, has been elected a member of the American Association for the Study of Neoplastic Diseases. Dr. Poling recently completed a study of tumors in the surgical laboratory at Johns Hopkins University.

Cincinnati—Dr. David I. Wolfstein, for the past forty years a leader in medical and civic activities of Cincinnati, has retired from active practice.

—O S M J—

In a recent opinion concerning payment from county funds for medical and surgical services rendered persons injured by or in the handling of animals afflicted with rabies, Attorney General John W. Bricker held that by virtue of Sections 5851 and 5852, General Code, county commissioners are required to recognize and pay from the general fund of the county claims found to be correct and just for medical and surgical expenses, including expenses for Pasteur treatment by persons who have handled animals afflicted with rabies, such persons at the time having scratches or other abrasions on their hands. Moreover, he held that inoculation by virus of an animal afflicted with rabies is an injury within the meaning of the term "or injured" as used in Section 5851, General Code.

—O S M J—

Warnings concerning the dangers of "Lash-Lure", an eyelash dye, have been issued by the Bureau of Investigation, American Medical Association, and the Federal Food and Drug Administration. *The Journal of the American Medical Association* editorially referred to recent "Lash-Lure tragedies" as strong arguments for legislation establishing national control over the sale of cosmetics.

SUMMARY OF FIRST YEAR'S EXPERIENCE IN PLAN OF DISPENSARY ADMISSIONS IN CLEVELAND

Appraisal of the Cleveland plan of dispensary admissions, now in its second year of operation and which attracted interest throughout the nation at the time of its inauguration in July, 1932, was recently completed, based on the first year's experience of the system.

The report of the Central Committee on Dispensary Admissions, administrative agency and headed by Dr. J. E. Tuckerman, published in the March, 1934, issue of *The Modern Hospital*, reviews the first year of operation, assembles opinions and criticisms of all interested groups, and presents the following general conclusions relative to the plan during its first year:

1. The plan is succeeding in returning to private practice about 25 per cent of the patients contacted by relief and welfare organizations, probably 50 per cent of those referred to physicians being ultimately returned to dispensaries and out-patient departments.

2. There is not uniform acceptance of the plan by agencies or workers owing to one or more causes such as failure to understand the plan, lack of sufficient instruction from the central committee, indifference and abuse.

3. Generally, there has been whole-hearted cooperation by physicians, agencies and workers.

4. Hardship has been imposed upon some patients by the plan.

5. There has been a definite improvement of the relations between dispensaries and private physicians and verbal reports from several hospital superintendents indicate that the number of complaints against the hospitals for alleged interference in private practice have decreased remarkably.

6. A large majority of the dispensaries, field workers and physicians believe the plan should be continued.

Questionnaires regarding the plan were sent to members of the Cleveland Academy of Medicine, the various dispensaries and to other agencies participating in the plan. The questions asked members of the Academy were answered by 303 physicians as follows:

Has the system increased your free work to an embarrassing degree? Yes, 15; no, 259; doubtful, 2.

Has the system helped you to maintain contacts with families who would otherwise have been lost to private practice? Yes, 146; no, 138; doubtful, 8.

Have you found the system has increased the intelligent cooperation between private agencies and your practice? Yes, 132; no, 114; doubtful, or have no knowledge, 29.

In your opinion is there enough value in the system to warrant its continuance? Yes, 172; no, 72; hesitant as to specific opinion, 36.

Would you be willing to care for indigent cases if drugs and medicines were furnished to patients whom you are serving without recompense? Yes, 196; no, 39; not answering or in a way difficult to interpret, 39.

The report states:

"Comments and criticisms were also sought in the questionnaire. Those offered by physicians were of three distinct types: Those showing inadequate understanding of the plan; those showing a biased point of view, and those showing an understanding of the plan.

"The first type of criticism added emphasis to the belief of the committee that more information for the physician is necessary to make the plan more effective. Biased comments ranged from arguments against all dispensary practice to comments on matters not covered in the questionnaire. Understanding comments and suggestions from many sources may be summarized as follows:

(1) Workers should indicate on the slips their understanding of the financial status of the patient. (2) More appreciation is needed on the part of the social worker and the public of the fact that the welfare of the medical profession is intimately related to the public welfare. (3) The impression that physicians are paid for their work in dispensaries or for their care of the poor in private practice should be corrected. (4) A plan for closer contact between agency worker and physician should be evolved. (5) Among abuses of the plan cited are the fact that the physician is practically forced to sign the slip sending people on to dispensaries and that too many physicians refer cases on to dispensaries without further inquiry."

A similar questionnaire sent to dispensaries and welfare agencies was summaried in the report as follows:

Has the system been of service to your agency or has it been a hindrance? Help, 24; hindrance, 6; doubtful, 7; not answering, 2.

Has the service helped to improve the relationship of your agency with private physicians? Yes, 20; no, or doubtful, 10; not answering, 6.

In your opinion is there enough value in the system to warrant its continuance? Yes, 32; no, 4; doubtful or not answering, 3.

The report gives the following examples of favorable comments received from these agencies on the plan:

Has helped to eliminate from the dispensary border line cases.

Has decreased the number of new admissions.

Has enabled agencies to know what physicians are willing to cooperate.

Extra work entailed has been offset by lessen-

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Patients take to it kindly.

It has made possible medical services for some who would otherwise have been without it.

Patients feel they receive better care at dispensaries when sent by physicians.

Patients feel they get better attention from private physicians.

Patients are relieved of long waits at the dispensaries.

The plan has lessened criticism of dispensaries.

Some of the unfavorable comments received on the plan from dispensaries and welfare agencies are summarized in the report as follows:

Loss of valuable time by the patient.

Too little contact with private physicians.

Most of the patients returned to dispensaries were re-referred by physicians not connected with out-patient departments of hospitals.

Some physicians take a "negativistic" attitude.

Patient has no means of getting prescriptions filled.

Additional car fare for patient.

Some do without care instead of returning to private physician.

Patients hesitate to go to a strange physician.

Patients canot secure adequate reports from physicians.

Summarizing some of the comments obtained relative to modification of the system to improve it, the report stated:

"Comments from the dispensaries suggest that 'we explore the danger of alienation of the private physician and his patient when such patient becomes a dispensary patient and is hospitalized'; recommend confining the use of reference blanks to dispensaries, despairing of 'teaching agencies other than dispensaries to respect the rights of the private physicians and believing that the medical profession and social service departments of hospitals might seriously accept the obligation of teaching other agencies in this respect'; suggest that families receiving material relief be sent direct to dispensaries; ask what becomes of the patient who, not accepted by the physician, fails to report back to the dispensary and what about the patient whom the physician continues to treat inadequately, until his small sum is exhausted and then refers him to a dispensary?"

Additional comments on the plan obtained by the committee include the following suggestions:

Reports should be made from physicians to dispensaries or field workers; the scope of the plan should be extended; arrangements should be made for filling prescriptions; the physician should be educated more adequately; physicians should set special office hours to care for these patients; blanks should be enlarged to provide more space for comment by the competent worker; better contact should be developed between the agency worker and physician; patient should be given the choice of accepting the plan or going to the dispensary; more adequate instruction needed on interpretation of principles.

Splendid Program Stimulates Interest In Cleveland Session of A. M. A.

Preliminary arrangements for the 1934 Annual Session of the American Medical Association, June 11 to 15, at Cleveland are rapidly being completed and present indications are that the Cleveland meeting may establish a peak for A.M.A. gatherings, from the standpoint of attendance and the quality of the scientific program.

The Cleveland Committee on Arrangements, under the chairmanship of Dr. C. W. Stone, is hard at work perfecting innumerable local details and making extensive plans for the entertainment of those who will attend.

Those planning to attend the Cleveland meeting should make their hotel reservations as soon as possible to insure satisfactory accommodations. A list of Cleveland hotels and rates for rooms was published on page 38 of the advertising section of the February 24, 1934, issue of *The Journal of the American Medical Association.* This list may be referred to by those desiring to make reservations. The reservation application form which accompanied this list should be sent to Dr. H. C. King, 1604 Terminal Tower, Cleveland, chairman of the sub-committee on hotels of the Cleveland Committee on Arrangements.

Practically all the principal passenger associations have established a rate of one and one-third fare for the benefit of physicians who will attend the Cleveland meeting. Those who desire to take advantage of the reduced railroad rates should secure from ticket agents at the time tickets are purchased, a CERTIFICATE, which, after it is properly certified to by the Secretary of the A.M.A. and validated by an agent of the railroads at Cleveland, will entitle the holder to purchase a return ticket over the same route traveled to Cleveland at one-third the regular fare.

All meetings of the sections of the Scientific Assembly and the General Scientific Meetings will be held in the Cleveland Public Auditorium which also will house the Scientific Exhibit, the Technical Exhibits and the Registration Bureau. Meetings of the House of Delegates will be held at the Hotel Statler.

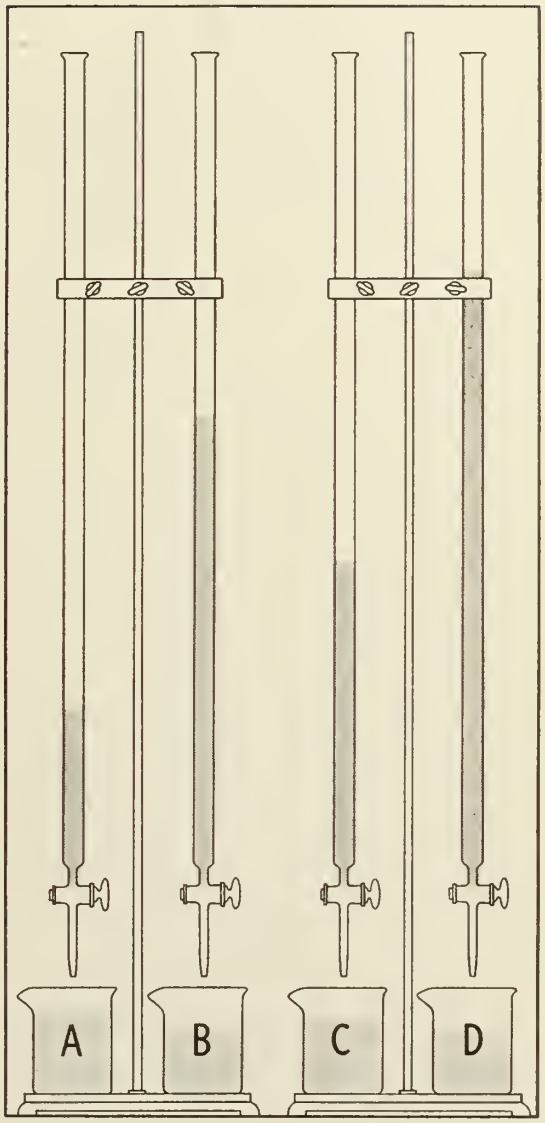
The Scientific Exhibit and the Technical Exhibits will be opened on the morning of Monday, June 11. Many applications for space have been received by the Committee on Scientific Exhibit, indicating that this particular feature of the meeting will be equal to, if not surpass, the splendid exhibits of recent A.M.A. sessions. Among the special demonstrations to be held in connection with the Scientific Exhibit will be one of fresh pathologic material collected daily from Cleveland hospitals. Moreover, there will be three special showings of current interest. These include a complete laboratory exposition of the pathology and methods of diagnosis of amebiasis; material on epidemic encephalitis, arranged by

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those who made studies of the St. Louis outbreak, and a practical exhibit of the newer methods in the treatment of burns. These exhibits will be correlated with papers and symposiums in the scientific sections.

Judging from the unusually large number of prospective essayists and the variety and importance of the subjects proposed for discussion, the programs of the Sections of the Scientific Assembly will be of the highest quality and interest.

The General Scientific Meetings will be held on the afternoon of Monday, June 11, and on the morning and afternoon of Tuesday, June 12. This part of the program has heretofore been known as the Clinical Lecture Program but from now on will be known as the General Scientific Meetings. An excellent program has been arranged for each of these sessions, the purpose of which is to keep the physician abreast with subjects of current interest. For this reason, clinicians and demonstrators who have achieved note either for their special work on the topics to be discussed or for their pedagogic ability have been selected. One of the features of these general sessions will be the program on amebiasis to be given on the afternoon of Tuesday, June 12, by some of the leading epidemiologists and clinicians of the country.

The Section on Miscelloneous Topics will devote one session to forensic medicine and a second session to nutrition. Both of these programs are in the nature of an innovation since neither of these particular subjects has been dealt with in separate section programs. The papers presented on these subjects will be supplemented by extensive displays in the Scientific Exhibit. Authorities from some of the leading criminal investigative offices of the country have been secured to discuss the current aspects of the scientific and medical investigation of crime. Likewise, experts in nutrition will discuss the application of diet to the control of disease and its influence on growth.

Carrying out the idea of arranging practical showings on subjects discussed on their programs, the various Scientific Sections have arranged special exhibits. For example, the Section on Obstetrics, Gynecology and Abdominal Surgery will present an exhibit covering the technic of delivery in the home; the Section on Ophthalmology will display methods of first-aid in injuries of the eye and the Section on Dermatology and Syphilology will have an exhibit in allergy.

The first meeting of the House of Delegates will be at 10 a. m., Monday, June 11. The opening General Meeting will be at the Cleveland Auditorium on the evening of Tuesday, June 12, and the President's Reception will be on the evening of Thursday, June 14.

Ohio physicians who are Fellows of the A.M.A. should be especially interested in the 1934 meeting inasmuch as many physicians who have found it impossible to attend past A.M.A. meetings frequently, will find it convenient this year to attend because of Cleveland's central location and easy access.

Registration and attendance is through Fellowship card.

—O S M J—

Legal Confusion In Law Relating To Hospital Reimbursement

Complying with a request of Glen M. Daily, state registrar of motor vehicles, Attorney General John W. Bricker has rendered an opinion interpreting a number of provisions of the Hesse Act (House Bill 80) enacted at the regular session of the 90th General Assembly and which became effective October 9, 1933, providing reimbursement to hospitals operating not-for-profit for services rendered to indigents injured in automobile accidents. (See page 722, November, 1933, issue of *The Journal*).

Specifically answering the questions raised by Mr. Daily, who is administrator of the fund of approximately $300,000 that will be established annually for this purpose by setting aside from the State Maintenance and Repair Fund 19 cents for each motor vehicle registered in the state, Mr. Bricker held:

1. Hospitals entitled to the benefits of the act may be reimbursed for the care and treatment of non-resident indigent patients suffering motor vehicle injuries within Ohio, which injuries occurred on or after the effective date of the act—October 9, 1933.

2. Such hospitals are not entitled to reimbursement for the care and treatment of residents who suffered motor vehicle injuries outside of the confines of Ohio even though such patients are brought back to the hospitals of this state for treatment.

3. Such hospitals are not entitled to reimbursement for caring for non-resident persons injured in other states and brought to hospitals in Ohio for treatment.

4. Such hospitals should not charge to the state fund the accounts of indigent persons who suffered motor vehicle injuries prior to the effective date of the act (October 9, 1933).

5. To meet the requirement of the act that a statement regarding the financial condition of the patient must be obtained by the hospital from a township trustee, municipal officer or director, or like representative of a special agency engaged in the relief of the poor, a hospital may secure such a statement from a township trustee, municipal officer or director, or (1) representative distributing federal, state and local relief funds, (2) a county officer who investigates persons receiving federal, state and local relief funds, (3) a welfare worker of a corporation who has hand-

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Evening programs will consist of addresses by nationally known physicians from other states.

A second Optional week will be available in any of the branches of medicine and surgery and the specialties. This week gives special emphasis to bedside and laboratory study. For further details write Registrar, of the Indiana University School of Medicine, Indianapolis, Indiana. A registration fee of $5.00 will be charged.

led all the relief work for their former employes, (4) a central agency which does the investigating for all relief agencies, including the charity patients accepted by hospitals, and (5) a social worker of a hospital which has a well developed social service department whose report is accepted by agencies dispensing federal, state and local relief.

6. "Indigent person" within the contemplation of the act means a person who has suffered a motor vehicle injury, is received and cared for in a hospital, is unable to pay, that is in the sense that if it appears that should an action be brought and judgment secured for the amount of the hospital bill against such alleged indigent or a party legally responsible for his care, execution thereon would be unavailing, and whose account remains unpaid for a period of ninety days after the termination of such care. However, the definition would exclude an employe suffering from a motor vehicle injury with respect to which he is entitled to the benefits of the workmen's compensation act of this or any other state or country.

No funds have as yet been disbursed to hospitals under the provisions of the act although claims from hospitals are being accepted by the Division of Motor Vehicles. It is likely, according to officials of that division, that disbursements will not be made until additional provisions of the act are clarified by opinions of the Attorney General or by the courts.

—O S M J—

College of Physicians Meeting

Eighteenth annual Clinical Session of the American College of Physicians will be held April 16-20, inclusive, at the Palmer House, Chicago. A number of Ohio physicians are scheduled to address the general sessions of the meeting, including: Dr. Charles A. Doan, Columbus; Dr. Louis G. Hermann, Cincinnati; Dr. Henry J. John, Cleveland; Dr. A. Graeme Mitchell, Cincinnati; Dr. Edward Muntwyler, Cleveland; Dr. John A. Toomey, Cleveland; Dr. Charles T. Way, Cleveland, and Dr. Bruce K. Wiseman, Columbus.

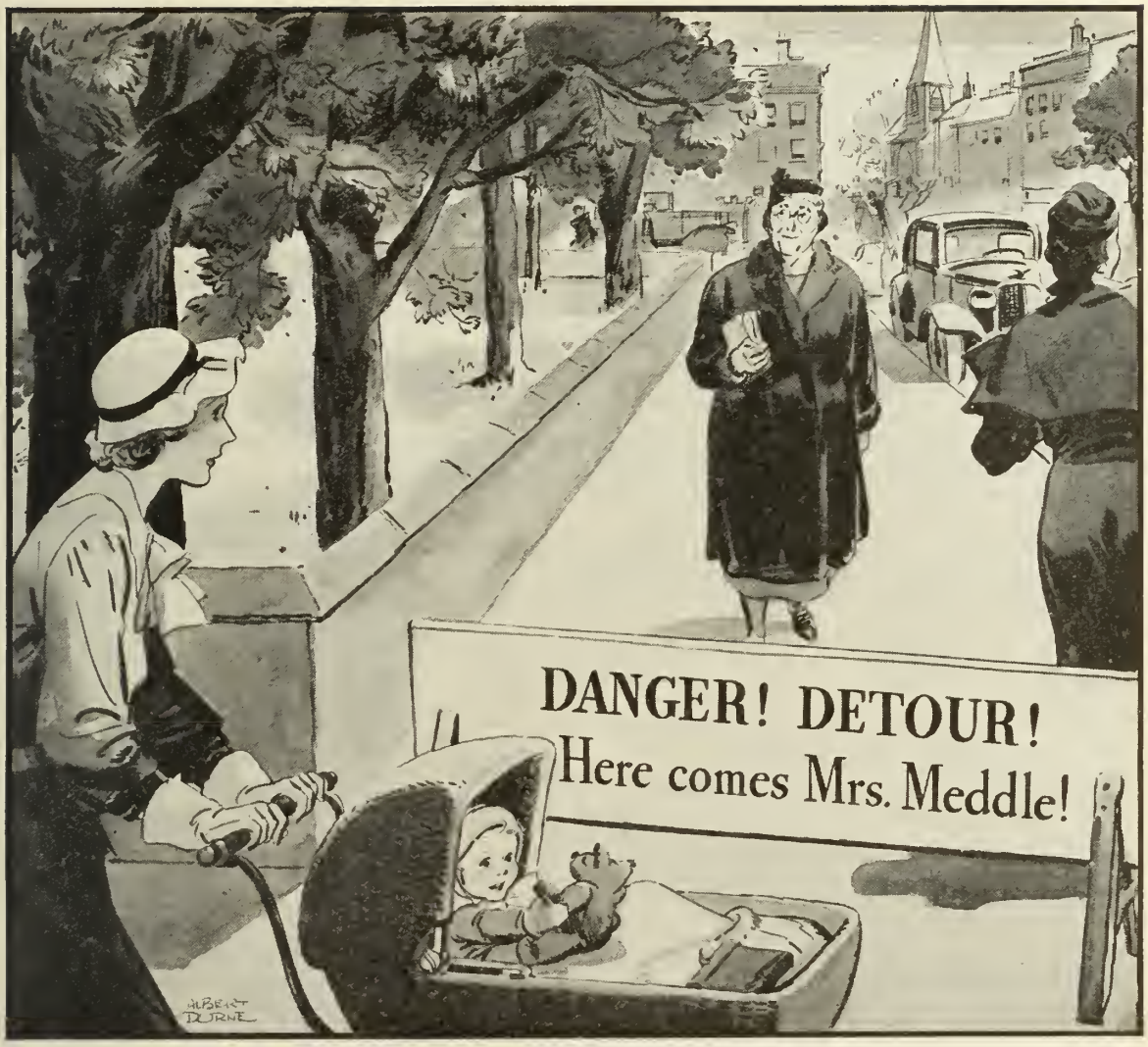
Inter-related Problems of Medical Education, Private Medical Practice and Hospital Service in Cincinnati

For the past month or two, the press of Ohio has published numerous articles relative to controversies regarding matters of policy involving the Cincinnati General Hospital and the University of Cincinnati between various groups of physicians, hospital officials and university officials in Cincinnati.

In order that members of the profession outside of Cincinnati may have information on some of the questions that have arisen there and the official position of the Cincinnati Academy of Medicine toward them, the following resolution adopted on January 22, 1934, at a meeting of the Academy, attended by approximately 500 members, is published herewith:

The following resolutions are presented to the Academy of Medicine of Cincinnati after serious thought on the problems confronting the medical profession of this city. Mindful of an illustrious past and hopeful of a future of accomplishment and advancement, these resolutions are offered to restore again to the profession those opportunities and encouragements which make for a united profession, and, in consequence thereof, better care of the sick poor of Cincinnati and better education for the medical students, internes, and residents. We ask no special favors nor special privileges. Our plea is both for a new deal and a square deal. We are simply desirous of bringing about better conditions in the medical institutions of our city, and are eager and willing to cooperate with those in authority. It is in this spirit and with a firm conviction in the justice of our cause that the following resolutions are offered:

(1) WHEREAS, We are aware that certain practices exist in the Medical School of the University of Cincinnati and the Cincinnati General Hospital which are unfair to the physicians of Cincinnati and to the institutions named and do not conduce to the cordial relations between the physicians and the aforesaid institutions, we as members of the Academy of Medicine, as taxpayers, and as representatives of a group giving freely of our time and services to the sick poor at the Cincinnati General Hospital and in the community do object to the diversion of funds to the end that staff members are supplied with offices, telephones, secretaries,



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etc., for the conduct of private practice inasmuch as the physicians in private practice, as taxpayers, help to contribute to the aforesaid services furnished to the staff. This practice is unfair and contrary to the spirit of justice.

Therefore, Be It Resolved, That no member of the Cincinnati General Hospital Staff or the College of Medicine be permitted to carry on private practice *excepting under such terms as those of the other physicians of Cincinnati,* which implies that the City of Cincinnati discontinue providing facilities for the handling of private patients to any and all members of the staff or faculty. This is not to interfere with men devoting their *full* time to these institutions seeing patients in consultation with other physicians; but in no case are laboratory or *X*-ray services to be rendered to the latter patients by the Cincinnati General Hospital.

(2) WHEREAS, It is known that different physicians contributing the same amount of time, skill, and effort to the aforesaid institutions receive greatly different compensation and recognition.

Be It Resolved, That physicians devoting equal time, skill, and effort receive commensurate compensation and recognition for their services.

(3) WHEREAS, It is known that *X*-ray and laboratory work done at the Cincinnati General Hospital is not confined to the needy poor of Cincinnati.

Be It Resolved, That such work be confined to the aforesaid individuals.

Be It Further Resolved, That only needy, poor outpatients shall be given this type of service and only upon recommendation of a reputable physician or recognized social agency.

(4) WHEREAS, It is known that patients not residing within corporate limits of Cincinnati are accepted and treated at the Cincinnati General Hospital to such an extent that our own needy poor are deprived of adequate hospitalization.

Be It Resolved, That the Cincinnati General Hospital confine its efforts to the adequate care of the poor and needy who reside within the corporate limits of Cincinnati, for which object said hospital was created, and that out-of-town patients be sent to the various private hospitals of the city.

(5) WHEREAS, It is known that no real contracts exist between the salaried members of the Medical College, and Cincinnati General Hospital, and the University.

Be It Resolved, That such agreements be entered into and made public to the citizens of Cincinnati.

(6) WHEREAS, It is known that considerable improvement can be effected in the care of the patients and the instruction of the students, internes and residents.

Be It Resolved, That the Academy of Medicine recommends a thoroughgoing investigation of these conditions.

(7) WHEREAS, It is known that resident physicians and internes at the Cincinnati General Hospital assist and take care of private patients in other hospitals and that this practice is unfair to the residents and internes of other hospitals,

Be It Resolved, That such internes and residents confine their duties to the care of the sick at the Cincinnati General Hospital.

(8) WHEREAS, The Christian R. Holmes Memorial Hospital is an institution owned, operated and conducted by the University of Cincinnati and all employes engaged in the management and operation of this institution are certified by the Civil Service Commission.

Be It Resolved, That the Academy of Medicine earnestly recommends that the Christian R. Holmes Memorial Hospital be converted into an institution that would render a greater service than the present institution affords.

Be It Further Resolved, That the proper legal authorities be appealed to in order to determine the legal right of the Board of Trustees of the University of Cincinnati to operate the Christian R. Holmes Memorial Hospital as it now exists.

Be It Further Stated, That the Academy of Medicine is mindful of the great contributions made to medical Cincinnati by Dr. C. R. Holmes and also is deeply appreciative of the philanthropy and liberality of Mrs. C. R. Holmes.

(9) WHEREAS, It is known that policies concerning the medical care of the needy poor of

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Fellowship a Prerequisite to Admission to A. M. A. Meeting

Because Fellowship in the American Medical Assciation is a prerequisite to admission to the Scientific Assembly of the Annual Assembly of the American Medical Association, to be held June 11-15, 1934, in Cleveland, Ohio, physicians who are in arrears with their Fellowship dues in the A.M.A should forward them immediately to the A.M.A. headquarters, 535 North Dearborn Street, Chicago.

All members in good standing in the Ohio State Medical Association are members of the American Medical Association and eligible to become Fellows of the A.M.A.

Those holding Fellowship in the A.M.A. are automatically subscribers to *The Journal of the American Medical Association,* recognized as the leading medical publication of the world. However, any one of the special journals published by the A.M.A. may be substituted for *The Journal* by those holding Fellowships. If the subscription price of the special journal selected is higher than the subscription rate to *The Journal,* the regular subscription price of the publication chosen must be paid, which price will include Fellowship.

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Cincinnati are adopted without consultation with the representative organization of physicians in Cincinnati.

Be It Resolved, That all policies concerning the medical care of the needy poor of this city be adopted only after consultation with an elected committee of the Academy of Medicine of Cincinnati inasmuch as some two hundred physicians are giving their time and service without compensaton to the Cincinnati General Hospital and the University of Cincinnati.

(10) *Finally, Be It Resolved,* That a copy of this resolution be sent to the City Council and the Board of Trustees of the University of Cincinnati with a request that speedy action be taken and that we be notified when the above resolutions are to be considered so that we can have representatives present.

—O S M J—

Lay Health Audit Bureau Is Routed By High Court

Efforts to confine the practice of medicine to those competent and licensed to practice medicine and to eliminate the corporate practice of medicine received considerable impetus recently when the Minnesota Supreme Court in deciding the case of John Granger vs. the State Board of Medical Examiners, held that a layman could not conduct a health audit service furnishing urinalyses and blood pressure tests through the medium of employing a licensed physician to do the actual work.

The plaintiff had sought to restrain the State Board of Medical Examiners from in any way interfering with the conduct of his business which consisted of the furnishing of periodical urinalyses and blood pressure tests to "subscribers" for a yearly fee of $10.00. The work was done by a licensed physician. The lower courts sustained the demurrer interposed by the Medical Board, which verdict was affirmed by the Supreme Court, which in its opinion held:

1. The plaintiff, a layman, in conducting a "health audit" for a fee for which he furnished his subscribers with the results of urinalyses and blood pressure tests and either himself advised, or passed on to the subscriber advice from the pathologist who made the urinalyses, as to whether the results showed a normal or abnormal state of health and whether the subscriber should see a physician, in some cases advising as to diet, exercise and habits, was practicing medicine unlawfully in violation of Sec. 5717 Mason's Minn. St., 1927.

2. In so doing he is practicing the science of healing in violation of Sec. 5705 Mason's Minn. St. 1927, which defines the science as including the diagnosis or analysis of the condition of human health.

3. Plaintiff's contract with his pathologist was illegal and in violation of statute and the public policy of the state.

The Court also held that the plaintiff was engaged in the diagnosis or analysis of the condition of human health and as such constituted a violation of the Basic Science Law. Sec. 5707 Mason's Minnesota Statutes 1927.

The Court summed up the entire matter by stating that the law intends:

"That the patient shall be the patient of the licensed physician, not of a corporation or layman. The obligations and duties of the physician demand no less. There is no place for a middleman."

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In gastrointestinal disorders, "Dextri-maltose has been preferred to the other sugars as apparently less irritating."—*E. Cassie and U. Cox: The examination of the gastric contents in infants, with some considerations as to the value of lactic acid milk in infant feeding, Lancet, 2:322-325, August 14, 1926.*

"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextri-maltose to be better in general in cases of fat indigestion (infantile atrophy)."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, V. 1, p. 418.*

In the treatment of decomposition, "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—*E. Feer: Text-Book of Pediatrics, J. B. Lippincott Co., Phila., 1922, p. 284.*

In infantile atrophy, "The carbohydrate should be increased by gradual addition of dextrimaltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—*L. Fischer: Diseases of Infancy and Childhood, F. A. Davis Co., Phila., 1925, V. 1, p. 285.*

In the case of a premature infant, "Dried milk with water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at the end of the first week."—*L. Fischer: Clinical notes in a series of premature infants, Arch. Pediat. 44:227-231, April, 1927.*

In the treatment of decomposition, "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours; the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—*C. G. Grulee: Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 265.*

With reference to hypotrophy: "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially-fed infants, New York M. J. 114:158-160, August, 1921.*

In athrepsia, "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weight are added."—*J. H. Hess: Feeding and the Nutritional Disorders in Infancy and Childhood, F. A. Davis Co., Phila., 1928, p. 278.*

Concerning the treatment of marasmus, "When the stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—*L. W. Hill: Practical Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 281.*

In the feeding of prematures, "As soon as there is a hesitation in the gain in weight, dextrimaltose No. 1 is substituted for the dextrose, in the same amount in the mixture, with almost invariably a gain in weight."—*F. B. Jacobs: Relation of irradiated food substances and ergosterol versus cod liver oil in childhood nutrition, Pennsylvania M. J. 35:164-167, Dec., 1931.*

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—*M. Jampolis: Infantile spasmophilia, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov., 1918.*

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextri-maltose,' for the extra carbohydrates; . . ."—*M. Ladd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

In pyloric stenosis, "With low dextrose tolerance, a maltose dextrin preparation may be added in whole or in part. Even where the dextrose is well tolerated and gain in weight has ceased, impetus to the weight ontake may be given by the addition of a maltose dextrin preparation."—*D. J. Levy: Pyloric stenosis and pylorospasm of infancy with especial reference to medical treatment, J. Michigan St. M. S., 21:166-170, April, 1922.*

With reference to the treatment of diarrhea, "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—*F. Lust: The Treatment of Children's Diseases, J. B. Lippincott Co., Phila., 1930, p. 145.*

In dyspepsia, "The carbohydrate must not be allowed to exceed 3 per cent. Dextri-maltose is the most suitable sugar."

In the treatment of decomposition (atrophy, malnutrition, marasmus), ". . . when there has been obvious improvement, dextri-maltose is gradually increased from 3 to 5 per cent."—*B. Myers: The nutritional disturbances of infancy, Brit. M. J., 1:1079-1083, June 21, 1924.*

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—c.g., dextrimaltose."—*L. G. Parsons: Wasting disorders of early infancy, Lancet, 1:687-694, April 5, 1924.*

In the milder cases of inanition, "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—*W. J. Pearson and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Son & Co., Phila., 1930, p. 116.*

In intestinal intoxication, "I have had more experience with dried skimmed milk in which 2 to 5 per cent dextrimaltose, barley or rice flour has been cooked, and the mixture subsequently fermented by lactic acid bacilli or soured with lactic acid, than with any other food except protein milk."—*G. F. Powers: A comprehensive plan of treatment for the so-called intestinal intoxication of infants, Am. J. Dis. Child., 32:232-257, August, 1926.*

Regarding the treatment of the marantic infant, "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—*C. S. Raue: Diseases of Children, Boericke & Tafel, Phila., 1922, p. 427.*

In spasmophilia, "Dextri maltose is the best sugar to use in these cases, in the proportion of 6 to 8 per cent."—*J. H. Reading, Jr.: Spasmophilia, Hahneman. Monthly, pp. 403-411, July, 1922.*

In the treatment of atrophy, "If the baby continues to improve, the next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose; . . ."—*H. Thursfield and D. Paterson: Diseases of Children, William Wood & Co., 1929, p. 105.*

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired; in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, p. 158.*

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—*J. H. West: Low fat, high starch evaporated milk feeding for the marasmic baby, Arch. Pediat. 48:189-193, March, 1931.*

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—*O. H. Wilson: The role of carbohydrates in infant feeding, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.*

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Important Medical Relief and State Workmen's Compensation Developments in This Issue

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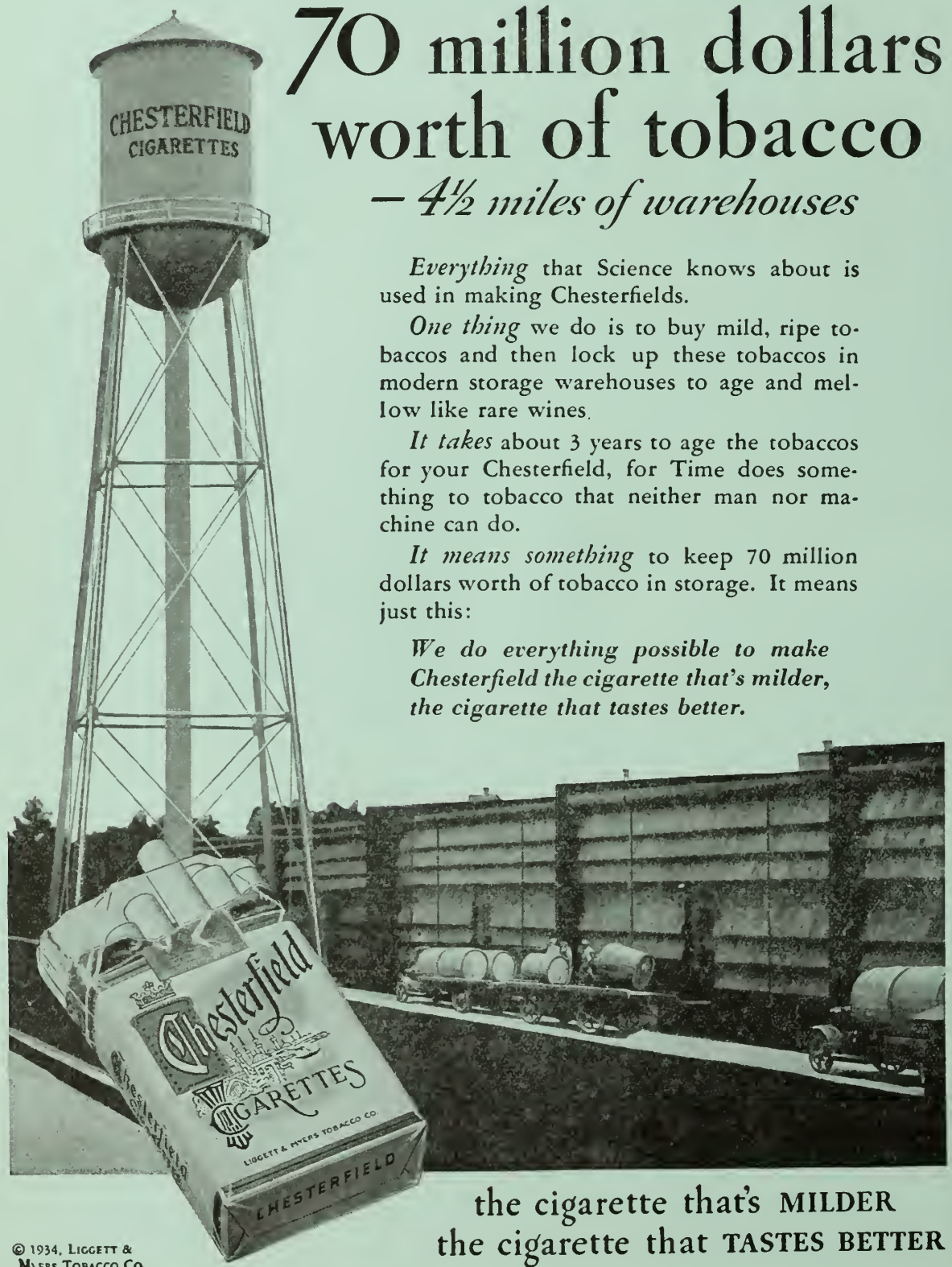
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Athens	C. H. Creed, Athens	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	L. E. Stenger, Lancaster	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	E. F. Hunter, Cambridge	Reo Swan, Cambridge	1st and 3rd Thursday each month.
Licking	Geo. H. Brown, Hebron	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3rd Tuesday, monthly.
Muskingum	M. A. Loebell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	James Miller, Corning	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	W. W. Sauer, Marietta	G. M. James, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
Hocking	C. C. Lyon, Logan	M. H. Cherrington, Logan	Monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	Anne D. Marting, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	Hubert Thurman, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	R. J. Caton, Bucyrus	J. A. Agnew, Crestline	1st Monday, monthly.
Delaware	Harold Davis, Ashley	J. G. Parker, Delaware	1st Tuesday, monthly.
Franklin	Verne A. Dodd, Columbus	John H. Mitchell, Columbus	1st four Mondays monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
Pickaway	D. V. Courtright, Circleville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
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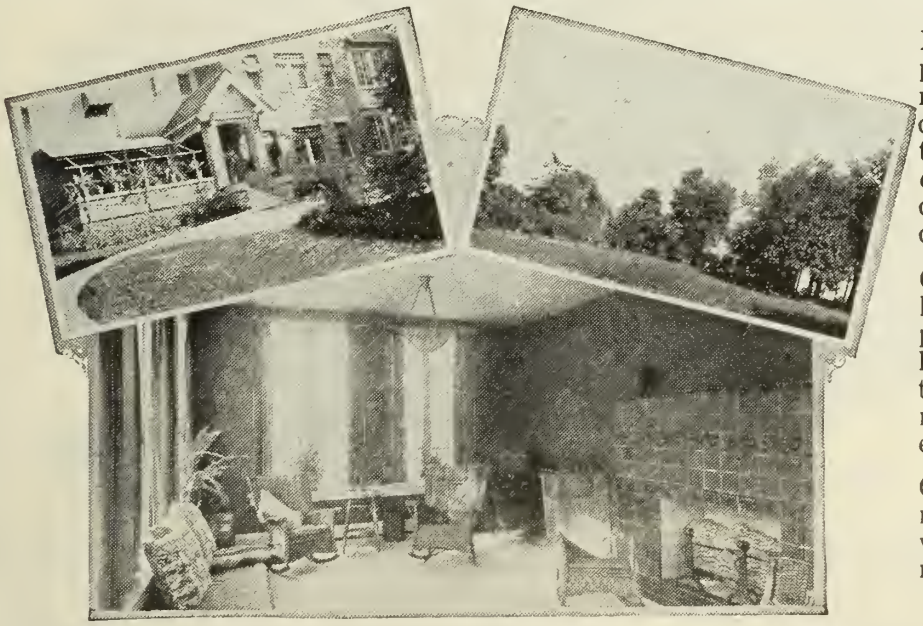


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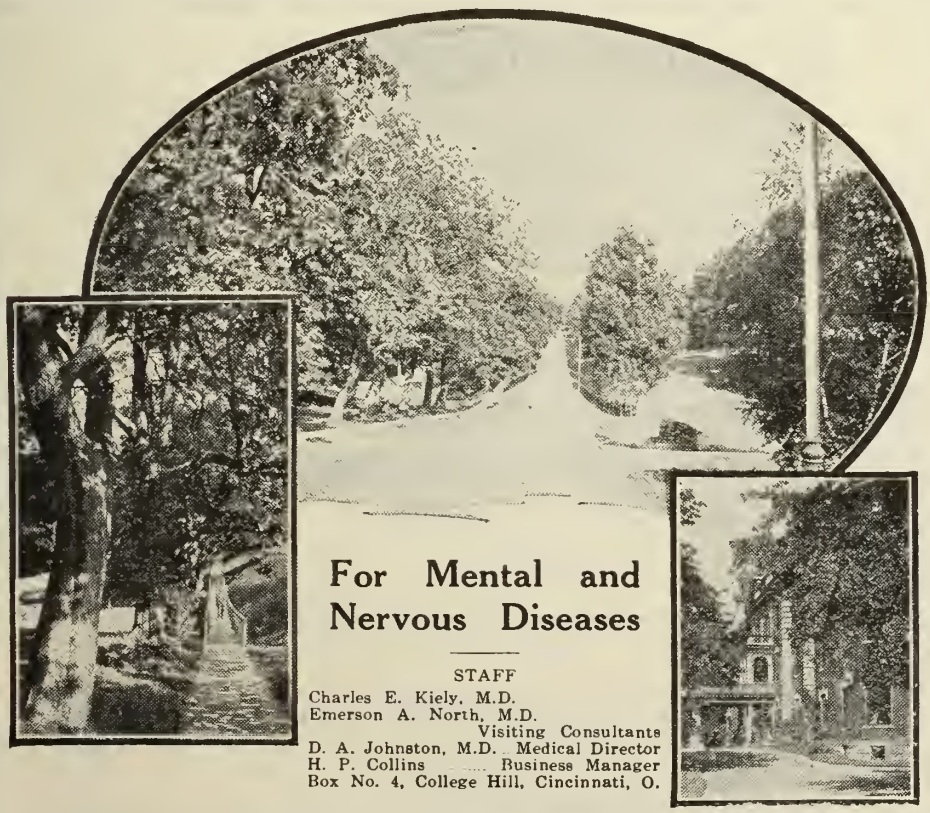
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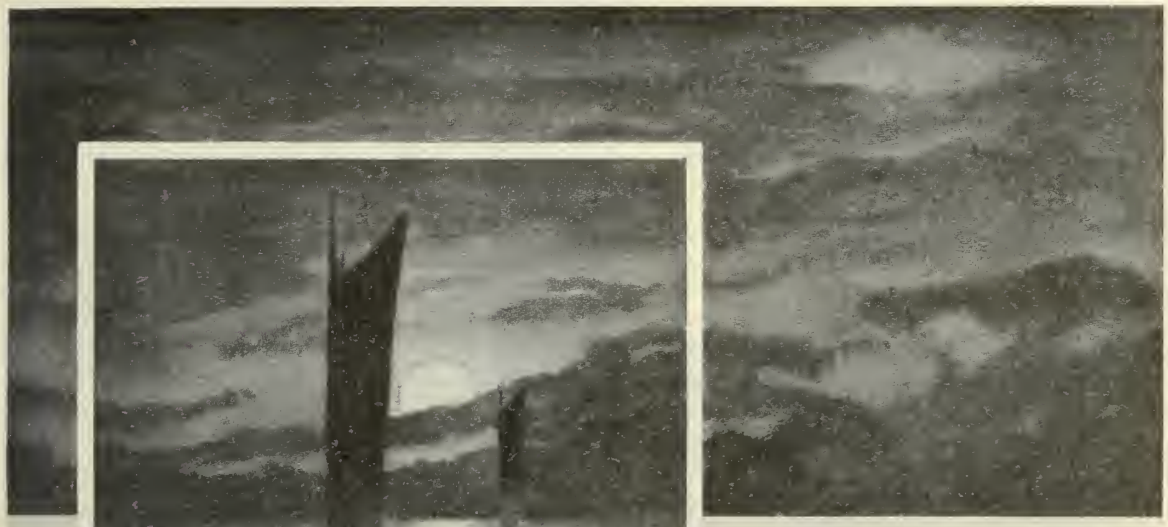
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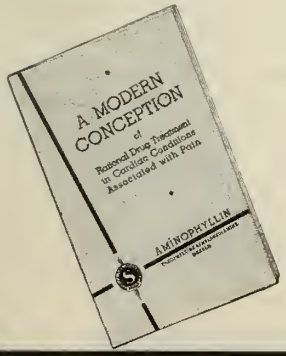


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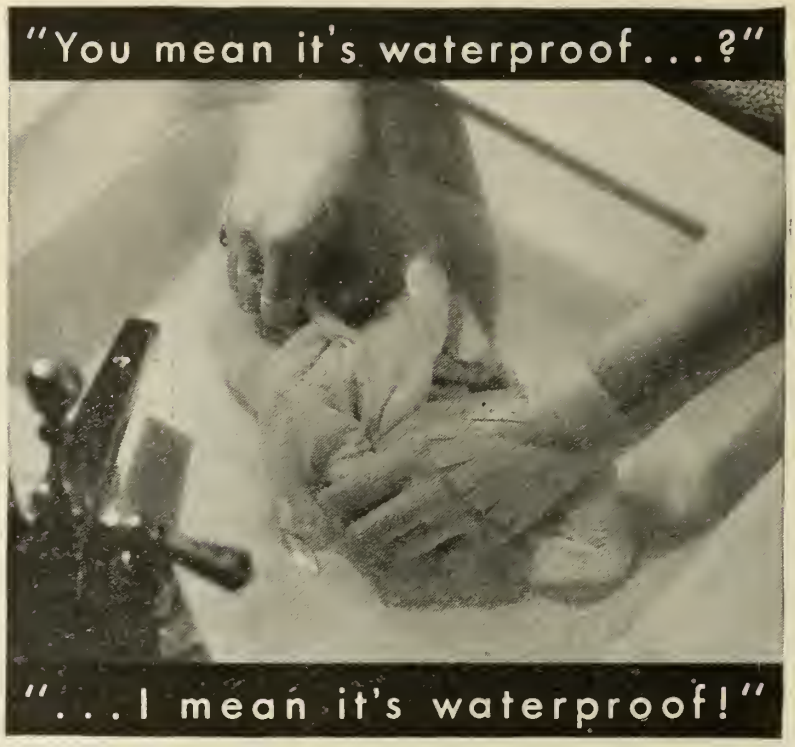
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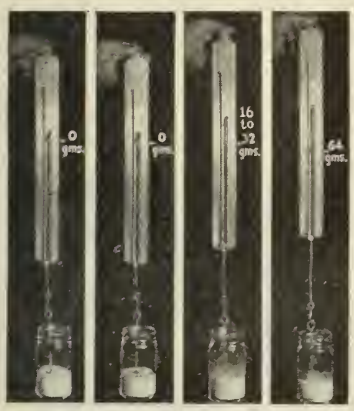
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[1] London & Polowzowa: Zeitschr. f. physiol. Chem. 1906, XLIX, 328.

[2] Marriott: Infant Nutrition, pg. 81.

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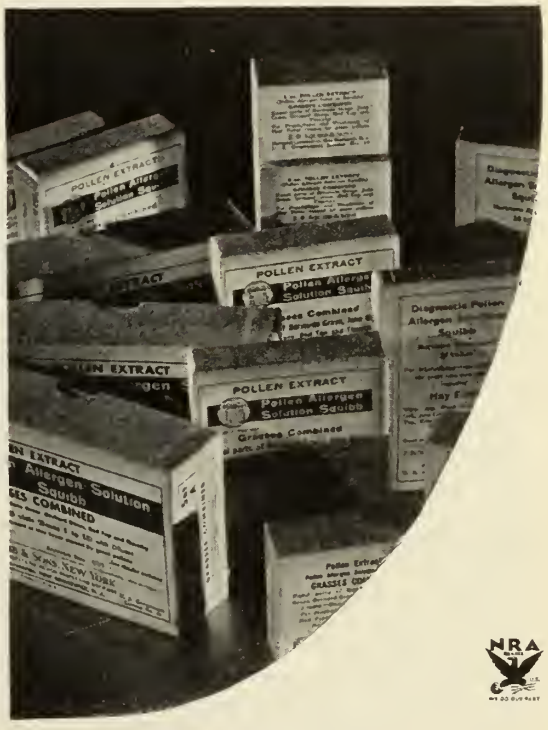
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

"If men whose needs are practically the same, who seek the same ends, could only come together in some sort of unity on a program, it would be comparatively easy to improve many bad conditions among us."

Improvement Through Unity

The foregoing quotation from Grove Patterson's column, "The Way of the World", in the *Toledo Blade* inspired Dr. M. D. Haag, president of the Toledo Academy of Medicine, to observe in the Toledo Academy *Bulletin*, that:

"Most of our difficulties as medical men could be corrected if we would all cooperate for the good of the entire group. The farmer is perhaps the greatest of all individualists but ranking next to him is the physician who has always sought to go it alone. If we could but get together, most of our troubles would be ironed out and we would command the respect not only of the public at large, but of other groups similar to our own."

Dr. Haag's comment deals with a problem that has long plagued the medical profession and has been a serious obstacle to the profession's effort to make its leadership in health and medical matters felt.

Disagreement among physicians has long been the source of jibes and jokes among the laity. It is natural for physicians to disagree on scientific matters. In fact, the tendency for physicians to question new theories and take a skeptical attitude toward unestablished methods in connection with the prevention and cure of disease has had a wholesome influence on scientific medicine. Advancement in medicine has come through dissatisfaction and the constant effort on the part of the profession to supplant old theories and procedure with new and better ones.

On the other hand, the profession has been backward in dealing with the social and economic questions affecting medical practice. Its failure to make its influence felt with the public on such matters is due largely to the inability of members of the profession to reach prompt and definite agreements on programs of activity. Few physicians are at variance with the principles on which the profession rests its case in dealing with public questions. Yet, frequently, the profession is unable to get into action quickly. Petty bickering over trivial details often prevents unanimity of action. Selfishness on the part of a few occasionally prevents a concerted effort to solve questions of vital concern to both the profession and the public.

Even now when it is of supreme importance that physicians present a united front and meet their problems in a spirit of active cooperation, a few members of the profession have balked. They have refused to go along with their colleagues in an effort to find answers for some of the complex questions confronting all of them.

Only constructive thought and activity, backed by harmonious and united effort, will give the medical profession the organized strength necessary to pull it through this uncertain period. Every physician has a right to his own ideas as to how the problems confronting the profession should be solved. If based on sound principles and policies, his suggestions are entitled to fair consideration and trial. However, in fairness to his colleagues and for the good of the profession as a whole, each physician should be willing to concede that the other fellow's ideas also may have merit. At any rate, all should be willing to go along with the majority until it has been definitely proved that the majority's program is obsolete and impractical, and should be supplanted by some other.

By pulling together and being tolerant even when personal viewpoints clash, physicians have a chance of controlling the future of medical practice. Unless they show a willingness to cooperate with each other in a sincere effort to solve their troubles, there is grave danger that those outside the profession will step in and solve them, perhaps in a way that will be detrimental to both the profession and the public.

OSMJ

Robert M. Paige, secretary of the Government Research Association, has expressed the opinion that 1934 will be a year of distinct *reform* of local government, pointing to the overhauling of administrative machinery in many of the 48 states to support his contention.

Changes Imminent In Local Government

The trend toward revamping the machinery of local government has been obscured to some extent by the events taking place in Washington. Nevertheless, it has begun in many localities and undoubtedly will lead to set-ups in many com-

munities widely different from those now in operation.

Here in Ohio the movement for change in local government machinery to remedy duplication and overlapping and eliminate financial waste has invaded many communities particularly following the adoption of the constitutional amendment in Ohio last fall permitting new local governmental set-ups. Naturally the financial crisis has added impetus to the demands for reform of both county and city governments. During times of prosperity the question of the effectiveness of government measured in terms of the taxpayer's dollar was largely academic or disregarded entirely. Now the taxpayer is becoming aware of the need for correction of defects, especially those which unnecessarily add to the financial burden he is forced to bear.

All of which adds emphasis to the appeal for greater and more active participation on the part of physicians, as citizens and taxpayers, in the affairs and functions of government, both state and local.

Physicians should feel it a duty to demand adequate public health administration on a sound basis but should vigorously protest changes that would prevent effective administration of the public health laws and ultimately prove disastrous for the public.

Simplification in government and reorganization on a scale that will distinguish between essentials and non-essentials are proposals which might well receive the support of the medical profession. When governmental changes are considered, physicians should make it a point to know what is going on and have a part in the formulation of the new program in each community.

OSMJ

The Profession In The Changing Social Order

That America in the near future must choose between a system of compulsory sickness insurance or one of outright state medicine is the prediction made by John A. Kingsbury, secretary of the Milbank Memorial Fund, in recent addresses before the Commonwealth Club of California and the Western Hospital Association at San Francisco, according to mimeographed releases on Mr. Kingsbury's talks sent out by the Milbank executive offices.

In his lengthy discussion of the subject, "Is America Headed For State Medicine", Mr. Kingsbury stated that America already has state medicine and predicted it will have more state medicine of the kind we already have, perhaps complete public medicine under the aegis of government, unless it chooses to adopt a plan of sickness insurance whereby the costs may be pooled and medical service continue to be rendered by private practitioners.

Mr. Kingsbury suggested an elaborate plan of sickness insurance, based on the investigations and recommendations of two of his associates, I. S. Falk, Ph.D., and Edgar Sydenstricker, as "a basis for constructive discussion" of the problems of medical care.

This mention of Mr. Kingsbury's comments and the Milbank Plan is not made merely for the purpose of publicizing Mr. Kingsbury or expressing an opinion concerning his "plan", but to again remind the profession of the increasing importance of preparing itself to meet, perhaps in the not distant future, strong efforts now under way to bring about radical changes in medical practice regardless of how the medical profession itself may feel about the matter.

The campaign sponsored by the Milbank Fund and other financially powerful groups to change radically the existing order in the field of medicine should not be discounted. Being past-masters in the art of propagandizing and possessing the resources to insure wide-spread circulation of and experimentation with their plans, these groups have succeeded in hastening the time when a decision must be made by both the medical profession and the public regarding the future course of medical practice and medical service in this country.

The medical profession may be justified in believing that the American public is not now willing to consent to the complete socialization of medicine. But, it should not feel too confident of the accuracy of this viewpoint, especially in view of broad social, economic and governmental changes that have taken place during the recent past.

The majority of the medical profession, perhaps, would welcome the arrival of the time described by Merle Thorpe when "a more temporate America will moderate the confusing judgments of the present by a sane evaluation of the past" and agree with him that "only in this way can the American Plan be maintained and improved and again be put to work". Thorpe expresses two texts for temperate thought: "Prove all things, hold fast that which is good; and "zeal without knowledge is a runaway horse".

Nevertheless, who can predict with confidence "a more temperate America" in the immediate future, or that the majority of the public will support "a sane evaluation of the past"? The medical profession dare not disarm itself by taking these things for granted. It should not accept blindly the statement that the public will not listen to new prophets especially in a rapidly changing social order. "Evaluation of the past" does not imply a *return* to the social structure of the past. Faith without judgment and action would be a fundamental weakness in medicine's argument.

One thing of which the medical profession can

be absolutely certain is that unless it is strongly organized and prepared to face the quetsion of socialized medicine and others of serious importance, with its ranks united and the machinery of medical organization functioning in high gear, it will run the risk of being swept from its rightful leadership in medical affairs. Unless there is concerted and harmonious activity on the part of physicians, headed by strong leaders and coordinated through the existing structure of medical organization, the profession may be delegated to a subordinated role in the final settlement of the great social problems confronting it.

Mr. Milbank and his associates have given the medical profession something to think about. Their activities and pronouncements are in effect a warning to each physician that unless he takes an active part now in maintaining and strengthening medical organization and in the solution of grave questions, he may in the near future find himself the victim of circumstances which might have been prevented through greater cooperation and united effort on the part of the profession at the present time.

OSMJ

County Basis of Organization

Occasionally suggestions have been made at medical gatherings relative to changes in the basic set-up of medical organization and arguments advanced in support of a plan for the organization of physicians by districts rather than on a county basis.

Sentiment for the substitution of a district organization plan for the present county-basis setup has met with little favor in Ohio.

In most instances, agitation for such a change has arisen in communities where the county medical society for various reasons has failed to carry out the purposes of medical organization and has neglected to provide for all its members those services and benefits which an active and energetic medical organization offers.

Pertinent comments regarding the machinery of medical organization and how it should function were made by Dr. J. W. D. Dicks, president of the Mississippi State Medical Association, in a recent communication to the members of that organization. Dr. Dicks' observations are especially in point inasmuch as the district plan of organization has been used extensively in Mississippi.

"In order that we may solve the problems that are confronting us we must organize," Dr. Dicks declared.

"As individuals we cannot stem the tide of public opinion but by organized effort we may be able to mould public opinion in our favor.

"I believe our plan of organization in this state can be improved. For several years we have drifted away from our original plan of organization—the county medical society. We have built up several splendid component societies, composed of a number of counties. These societies furnish fine professional programs for their meetings and the programs are instructive and interesting. Occasionally the programs are perhaps devoted too much to the specialties rather than to subjects of benefit to the general practitioner who composes the large majority of our members. The economic problems confronting our profession are conspicuous by their absence from these programs. In fact the large societies are not so constituted that they can take up questions affecting the material welfare of the physicians in their territory. The economic conditions are not the same in all counties. The problem has a different setting in each county and can only be solved by the physicians in their respective counties.

"It would not in any way disturb our component societies. I think they should be continued as district societies whose function should be to furnish instructive interesting professional programs only. * * * I believe we should organize county medical societies in each county where possible. There are extremely few counties in the state where the number of eligible physicians is too small to have a county society."

The point emphasized by Dr. Dicks is that in the final analysis the county unit is an indispensable part of medical organization and that a strong central state organization cannot be maintained unless each county is properly and sufficiently organized.

There are at present in Ohio several well-organized district medical societies. They have made a splendid record through their well-attended annual, semi-annual or quarterly meetings and the meritorious programs presented at these gatherings. They are useful organizations and have done much to provide instruction for the physician in active practice.

However, as Dr. Dicks has pointed out, the district medical society should not and cannot supplant the societies of the various counties within its district. It can, and should, however, be a valuable supplemental activity for the various county societies of the district.

Many of the troublesome problems confronting the medical profession are local in scope and effect, differing in various localities. For that reason it is essential that the physicians in each county be organized and see to it that their county society functions effectively.

Ohio is fortunate in having an exceptionally large number of active, energetic and alert county medical societies. The fact that a few county societies have been inactive and disinterested is no reason for a change in the basic set-up which calls for organization of the profession by counties through which local problems of vital concern to every physician in the county can be met in a much more effective way than by groups organized by larger districts.

It might also be added that the county unit is vital for proper representation in the House of Delegates of the State Association, for local civic relationships, and for activity on social and governmental problems, so vitally affecting medical practice.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

In a recent number of the *Journal of the American Medical Association** appears an editorial commendation of the new policy of the *New York State Journal of Medicine* which in the future will carry only clean advertising and will be free from announcements of questionable products. To our members it should be a source of pride that the *Ohio State Medical Journal* adopted an advertising policy of this sort years ago. Since that time its pages have been open only to the advertisements of pharmaceutical preparations conforming to the standards of the Council on Pharmacy and Chemistry of the American Medical Association.

In the same editorial was also a reference to a change in the policy of the *Journal of the Wisconsin Medical Association.* In the future, its editorial board will select from the manuscripts read at the state meeting those which it deems suitable for publication. This policy has been in force in the conduct of our own *Journal* for some time. While a paper delivered before a general or a section session at the annual meetings becomes the property of the Association, the inference cannot be drawn that it necessarily will be published in *The Journal.* Although the Publication Committee has the first right to use it, there is no obligation to do so unless it fulfills the high standards which the committee has established. The committee has felt obliged to refuse occasional papers even though presented at meetings of the Association and its action has been upheld by the Council.

Increasingly high standards both as to the scientific content and literary character of published papers have been set by the committee in recent years. Meanwhile it has been mindful of the fact that *The Journal* should carry papers of clinical interest to the general practitioners composing the great majority of our membership who look to *The Journal* for information about the newer conceptions and methods in medical science and practice. Not being obliged to limit itself to papers read at our annual meetings, *The Journal* not only welcomes but solicits volunteered articles possessing these qualifications.

The place occupied by *The Journal* in the activities of this Association is, and should be, a conspicuous one, for it serves as a means by which our organization is able to achieve in part one of its principal purposes, the dissemination of knowledge. Members who are prevented from attending an annual meeting of our State Association must depend upon *The Journal* for their knowledge of the splendid scientific transactions and organization activities at these gatherings. While many of our members are also Fellows of the American Medical Association, receiving its *Journal* regularly, unfortunately there are about 1,969 who are not. Therefore to this number our medical journal may be the only medical periodical received aside from the thinly disguised advertising magazines of the commercial houses.

In addition to its scientific and educational purposes, *The Journal* has another one, scarcely less important, and that is to serve as an instrument for organization purposes. To this end it carries timely informative articles and editorial comments on current economic, legislative, and social movements, especially those directly affecting the medical profession of Ohio.

The portions of *The Journal* devoted to the proceedings of county societies, hospital notes, obituary notices, personal items and general medical news are of great contemporary interest and will have definite historical value in days to come. All in all, our *Journal* is an institution of great merit, one deserving the enthusiastic interest and support of our members and well worthy of their pride.

(Foot-note:—Jan. 27, 1934, 102, 297).

PRE-OPERATIVE PATHOLOGY IN ITS RELATION TO POST-OPERATIVE GALLBLADDER DEATHS

By DUDLEY W. PALMER, M.D.,
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IT became the accepted procedure, some twenty years ago, to operate upon the patient with appendicitis as soon as the diagnosis was established. Gallbladder surgery is today, in the author's opinion, in that evolutionary period that appendix surgery has traversed.

A review of a series of deaths in surgical biliary disease and the associated pathological conditions is the basis for the above statement, The material consists of some fifty-six consecutive fatal biliary cases, occurring in the past fifteen years of practice, ending December, 1932. They include all hospital deaths whether surgical or not and those post-operative deaths occurring soon after dismissal from the hospital where the primary cause of death was directly connected with the hepatic tract.

The listing of the associated pathology in this series of cases is a summary of information obtained from the clinical diagnoses during the surgical exploration, and from post-mortem findings in about 20 per cent.

Dr. Frank Lahey of Boston recently said, "Our medical friends must overcome the complacency with which they permit patients to go through repeated attacks of gallstone colic". Dr. Willard Bartlett of St. Louis said, "Do not let patients go past fifty years, the dead-line for elective surgery, with a chronic disease." Dr. William J. Mayo said, "An innocent gallstone is a misnomer."

The fifty-six fatal surgical cases averaged fifty-seven and a half years of age as compared to an average age of forty-three and two-tenths years in the last one hundred consecutive cases of cholecystectomy, and of forty-five and five-tenth years in one hundred cases of cholecystostomy. This greater average age represents delay and an opportunity for increased pathologic involvement. Death has been in the proportion of forty-four females to twelve males, that usually given for gallbladder disease. The histories of the fifty-six fatal cases averaged twelve and three-fourths years in length as compared with six and one-tenth years in the last two hundred non-fatal cases. The longest fatal case history was thirty-eight years.

Pregnancy: The histories of the forty-four women state that thirty-two of the forty-one married women had been pregnant. This item of pregnancy may be a help in diagnosis, for the number of patients who have said their first colic attack occurred when they were "carrying Johnny" or soon after "Johnny was born", has been noteworthy. Many of these patients have been questioned as to whether they were told the meaning of the attack, or what should be done to prevent its recurrence while still in good health, and it has been surprising how many had had no advice as to the future and the attack was treated as a passing incident. Pregnancy is a factor in the metabolic changes producing or leading up to gallbladder morbidity, but there is no evidence that pregnancy alone increases the mortality.

The conclusion could not be drawn that typhoid or other infectious diseases have been important in influencing the mortality, but the relationship is, like pregnancy, largely of etiological significance.

Over-weight and rapidly increasing weight may be factors indicating pathologic metabolic processes as they stand out prominently in this study. Marked under-weight, and especially recent great loss of weight, are serious indicators. In fifty of the fifty-six histories the weight is stated, and thirty-five of these had a weight of one hundred and fifty to two hundred and seventy pounds, and ten a weight of from ninety-two to one hundred and thirty-five pounds.

It is difficult with scientific accuracy, to separate pathology found in the desperate-risk case, from pathology that might have arisen in a similar individual in the absence of gallbladder disease; in other words, it must be granted that it cannot arbitrarily be said that gallbladder disease is the only cause of associated pathology in any given individual, but it is known that certain conditions bear the relation of cause and effect to gallbladder disease. With reason, we must agree that when an organ as important to the chemical body economy as the liver is hampered a disaster will result. Therefore, we may conclude that many of the conditions found associated in these fatal cases may be the result of biliary disease and if the complications of this disease had been absent in any given individual, the probabilities of recovery and a healthful, longer life might have been greatly enhanced.

Heart. Numerous papers have been written on the association of gallbladder and cardiac disease. Frequently these are desperate risk cases. Arrythmias, myocardial, valve lesion and blood pressure changes including hyper- and hypotension have not generally received sufficient attention. Any variation in the circulatory pressure of the liver or of the supply of blood for it (the greatest chemical laboratory of the body) to

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work with may be of great moment when the laboratory itself is handicapped or has had its normal factor of safety reduced from nine or ten to one, to two or one to one. In the latter situation, the slightest change is often of vital moment. In the middle age or older group, a suspicion of cardiac handicap demands careful preparation by rest, elimination, and digitilization in mild degree at least.

The vicious circle of a failing liver function in face of cardiac deficiency does not permit any time to tone up the heart in the presence of the emergency. The unappreciated cardiac handicap may have great influence for harm in furthering a complication in a liver struggling for sufficiency. Even a little break quickly establishes a vicious circle which is a fatal factor in a few hours. The ebb and flow of hepatic congestion in the mild cardiac case becomes a tidal wave during the few hours of the post-operative load. The respiratory handicap from chest muscle and diaphragm limitation will be a factor in these cases of widespread involvement. A part of this picture is the chronic respiratory infection for, while this in and of itself would not be fatal, it may be the final drop in the bucket, adding a load to a heart and in turn to the already handicapped liver. Kidney involvement is another factor.

In the series of deaths there were nine cases where the symptoms warranted placing on the death certificate as part of the diagnosis, acute cardiac dilatation, or myocardial failure, and in seven of these nine the heart was known to be involved prior to operation. In the nine there were four common duct cases, three drainage cases, one cholecystectomy and one bowel obstruction by stone. A very earnest effort has been made to avoid the "heart failure" type of diagnosis, as it shifts the blame to the inevitable in too great a degree.

Cancer. Cancer as a cause of death in gallbladder surgery is taking its steady toll in the older age group. In this series of fatal cases there have been eighteen instances in which the diagnosis of cancer of the gallbladder was made, with an average age of sixty-eight and five-tenths years. The diagnosis of stones in the gallbladder was positively established nine times by palpation of the stones, and by *X*-ray in two additional cases not operated upon. Three others gave a stone colic history that seemed to warrant that diagnosis. There were four cases in which the gallbladder was so buried in malignant tissues as to make impossible the palpation of stones. Thus in eleven of the eighteen cases a "stone" diagnosis was established beyond doubt, while in the others it was a logical deduction. Stones long present in the biliary system seem to be the big factor leading to malignant changes in the involved tissues.

The diagnosis of cancer of the gallbladder was established at operation in thirteen of the eighteen, though in four of these it was too far advanced to make the differentiation absolutely positive as to whether it had been primary in the gall-bladder or liver. In the five not operated upon, the diagnosis rested upon the fact that the mass was in the region of the gallbladder in patients with gallbladder symptoms. These latter cases were considered inoperable because of either pelvic metastases found per rectum or other evidences of metastases; one patient was eighty-six years old. The subsequent histories verified the cancer opinion. I have living only one case of primary cancer of the gallbladder; four years after the cholecystectomy a cure appears to have been etsablished. This was a very early case, the diagnosis following a routine microscopic examination of the excised gallbladder. It surely seems that one is justified in stating that a death rate in the complicating cancer cases of 94.7 per cent, perhaps 100 per cent, is of sufficient moment to warrant the consideration of surgery, early before the chronicity of the gallbladder disease raises the possibility of cancer. In early uncomplicated gallbladder disease cases the death rate is very considerably below that of the rate occurring from the cancer complication alone which is given as from 2 to 4 per cent in different clinics. (DWP. 3 1/3 per cent).

In two instances the cancer occurred some years after cholecystostomy. There was no instance of cancer of the biliary system developing after a cholecystectomy. Two of the gallbladder cancer cases that were fatal should not have died because of the cancer, for the cancer was small and an accidental finding. They died of far advanced vital complications, that is, advanced cirrhosis in a man some sixty-three years of age with a history of attacks associated with chills and fever covering a period of thirty-three years; and a cardiac case in which death occurred forty-eight hours after operation from the shock of an embolism in the right subclavian artery with evidence of complete circulatory block in the arm. Only three of nineteen cancer cases therefore, were operated upon early enough so far as the cancer is concerned, to hope they might have been cured. It is only in the instances of the accidental cancer finding that hope of cure can be entertained.

Common Duct Obstruction. A common duct obstruction is a complication occurring at an earlier age, on the average, than cancer but late in the life history of the gallbladder case. It was fifty and six-tenth years in this series, with twenty-four the youngest and seventy-four the oldest. Again the average length of history of eight and four-tenth years is an indication of delay in obtaining relief. Twelve deaths or 21.4 per cent of the total number of deaths were common duct cases. Classifying these deaths causes certain re-

grets but even so the end result seems justified. The greater number of these patients were jaundiced, had low resistance, often had cardiac and nephritic symptoms; the respiratory interchange was hampered by the prolonged operation, the dressings, and in some instances there was localized infection of the lung, liver or peritoneum. Hemorrhage had to be prevented or combated in all jaundiced individuals.

In this duct group associated infection ended in three pneumonia deaths. There were four cardiac cases, one being associated with a plus four maximal jaundice and one had had two cholecystostomies and common duct operation before. One cholemic hemorrhage death occurred even though the patient had been protected by calcium medication and blood transfusions. Other associated lesions were shock in a fistula case with stone in the papilla of Vater; an abscess of the liver in a patient who had had two gallbladder oprations; malnutrition six weeks after operation associated with fever and advanced cirrhosis of the liver, the patient having had two gallbladder operations; "liver suppression" with plus four jaundice and cirrhosis plus two; kidney suppression; cholorrhea; cholorrhea is a condition that may be compared to the low specific gravity output of the small white kidney. The patient had at autopsy advanced biliary cirrhosis, mitral fibrosis, colon bacillus cholangitis, and toxic nephritis. The unusual feature was the excess bile discharge from the common duct "T" drainage tube, the amount collected being from forty-nine to fifty-two ounces a day, over many days. This causes an excessive chloride loss which was not then appreciated, but which loss now may be combated as I since have had one case recover.

There has been one other fatal painless jaundice case with advanced cirrhosis and cholangitis, in which the cholorrhea was remarkable as the maximum amount of bile discharged in one day was one hundred and sixty-nine ounces (five quarts, nine ounces). Dr. J. L. Tuechter made the post-mortem examination and found no cause for death other than listed above.

Thirty-nine per cent of the common-duct cases I have seen in private practice have had biliary tract operations earlier, thus adding greatly to the pathological handicaps to be dealt with, as shown by the fact that of the twelve common-duct deaths five or 41.7 per cent had had other gallbladder surgery before submitting to the final fatal operation. Two of these had had cholecystectomy, one cholecystostomy, one cholecystostomy and a cholecystectomy, and one had had two cholecystostomies and a common-duct operation.

Bowel Obstruction. In my experience bowel obstruction grom gallstones has occurred five times with a mortality rate of 60 per cent. The average age of these patients was sixty-four and one-half years, again delayed cases. The two cases recovering from the obstruction were those in which the stone was passed on down to the rectum and digitally removed therefrom. They had been sent to the hospital by the family physician as "bowel obstruction" cases. The other three patients were operated upon for small bowel obstruction and they died with symptoms of four, four and five days' duration. A small bowel obstruction lasting four days is almost 100 per cent fatal. I have had no experience giving me the opportunity of judging the result in early cases of gallstone bowel obstruction, but I know of no reason for thinking it other than that in the usual obstruction case. A follow-up on the two cases that lived after obstruction symptoms and passage of stones, indicates that in spite of much complicating pathology an operation is not necessary. The spontaneous cholecystenterostomy is satisfactory and eliminates the effects of the complicating pathology.

Rupture of a gallbladder is a result of ulcerative processes due to pressure of stones or from empyema. Death occurred in two of the six ruptured gallbladders; they also contained stones. A mortality of 33 1/3 per cent. One patient died of diffuse bile peritonitis six hours after admission to the hospital on the fourth day from the onset of the symptoms, and the other death might be charged to an advanced myocarditis, the patient having been in bed for six months with decompensation symptoms before the onset of the fatal acute cholecystic and peritonitis symptoms. One is certainly justified in feeling that an average death rate of 33 1/3 per cent in cases of ruptured gallbladder may be expected, a mortality far too great to justify the delay.

Embolism. This occurred as a cause of death five times. In two patients jaundice was present and four had liver damage grossly evident at operation and in an amount to alter, perhaps, blood coagulability. One of these tragic accidents occurred while the patient was being given a gastric lavage. One embolism was cerebral and one previously mentioned, into the subclavian or axillary artery. In a young woman there was no known cause for the embolism that might have been anticipated. In the other four embolism deaths there was sufficient co-existing pathology to make one wish they had come for operation a few years earlier.

As an example of too much surgery or perhaps a complication occurring as a result of surgery done for co-existing pathology in addition to that of the biliary problem, there was one death due to acute bilateral pyelitis coming on the ninth post-operative day in a patient married seven years, who had an almost complete congenital atresia of the vagina. Rather forceful dilatation and packing of the vagina may have been the etiological factor in the pyelitis. I find I am more and more fearful of gallbladder operations that

are combined with other procedures, although I still make a reasonable effort to remove an appendix that can be reached through the fairly long gallbladder incision, but I have given up making a second incision for this purpose. Certainly some biliary operation deaths can be charged to an attempt to clear up too much pathology.

There have been two jaundice patients (one common-duct case reported) who have had fatal cholemic hemorrhages. I am inclined to believe these cases represent some factor other than common-duct block alone. The liver function must be greatly disturbed also. My impression is that the bleeding of a patient with jaundice due to stone block with a good liver present, can be controlled by transfusion and calcium, but the same jaundice complicated by severe hepatitis is not so easily controlled. Glucose, calcium, and blood have not done it for me.

Only four of the deaths had pneumonia as a factor. For this I feel no need of an apology in view of the fact that upper abdominal infection plus the high incision with strapping, all greatly limit diaphragmatic excursions and so contribute to lung congestion. Three were serious common-duct cases already referred to and one case was of gallbladder gangrene.

Ileus. The three deaths attributed to acute dilation of the stomach or gastro-intestinal ileus were associated with but little visceral pathology. One had a grade two hepatitis, one mild nephritis, and the third occurred on the fourth day after a general anesthesia with sodium amytal given intravenously. The paresis problem is before us at an "any age" period; it is not peculiar to liver surgery. To date it is one factor uneliminated.

There was one death from general peritonitis in a patient with a hydrops of the gallbladder and grade two hepatitis upon whom a drainage operation was made. At post-mortem a satisfactory cause for the peritionitis was not found. The pathologist reported a cirrhosis of plus four degree with brown atrophy of the liver and a bronchitis as the unusual findings. Two cases died from peritonitis due to acute pancreatitis, both having associated gallstones.

Liver Dysfunction. Several articles have recently appeared on the subject of "liver deaths". In my series of fatal cases, the dictation of the operative procedure and findings, made the day of operation, states there was present, based on the appearance and "feel" of the liver at the time of operation, a grade number one hepatitis in thirteen cases; grade number two hepatitis in fifteen cases; grade number three hepatitis in seventeen cases; grade number four hepatitis in nine cases; and no hepatitis in two cases (paralytic ileus and cerebral embolism cases.) A total of fifty-six cases with an average of 2.33 hepatitis.

In the last one hundred cured surgical gallbladder cases the grading of the hepatitis present, made at operation, was as follows:

Grade number one hepatitis in forty-six cases; grade number two hepatitis in twenty-five cases; grade number three hepatitis in five cases; grade number four hepatitis, none; no hepatitis in twenty-four cases. An average of 1.1 hepatitis.

A normally functioning liver I believe cannot exist in the presence of a decompensated heart, myocardial handicap, respiratory disabilities, nephritis, alimentary dysfunctions, chronic infections at any site, or biliary tract disease. One or another of the liver functions will be disturbed. The reverse is just as true. We have tests of liver function that are relatively good and of value for some one corresponding function. No one test for all functions has been devised nor will it be, in all probability. It is regrettable that one cannot say with precision how close a liver is to the breaking point. Every surgeon has undoubtedly seen bad nutmeg livers at operation with the patient recovering, and on the other hand, he has seen liver deaths in patients who at operation have shown only a moderate hepatitis as judged by swelling, engorgement, whitish livers, scarring, or rounded edges. I have seen patients with an icterus index of sixty-four plus and ninety-six plus get well, and one patient with an index of six die.

I cannot indicate the point at which laboratory evidence of liver dysfunction becomes a serious menace. Dr. H. L. Smith of the Christ Hospital, (Cincinnati, Ohio) Research Laboratory is doing promising experimental work to establish criteria of liver damage or impairment of function as an aid to pre-operative diagnosis and prognosis in the gallbladder case with associated hepatic pathology. He says, "Certain experimental evidence demonstrates that metabolism of bile-salt, sterol, phospholipids and neutral fats is associated to a large extent with liver functioning. Other evidence shows a peculiar interrelation in the metabolism of these constituents. When a large amount of substance, similar in certain properties to one of the bile salts, appears in the blood stream a decrease of blood pnospholipids usually follows—and vice versa. Then again, when the liver fails to secrete bile salts into the gut, large quantities of free and total cholesterol appear in the blood. With these facts in mind we have to learn more of the metabolism of each of these substances by studying their occurrence at different times in the blood of normal humans and patients suffering from liver and gallbladder diseases".

Drawing conclusions from the fatal cases in which one or more liver tests have been made, it seems any evidence of dysfunction is a warning signal to be carefully observed. Each additional bit of evidence of liver disease has made me more and more respectful of the hovering dangers. The liver, when things are running smoothly and the

human engine without a load, apparently can be doing a 100 per cent job; add but a little load and the "engine" stalls. The border-line kidney we have known about for some time; of the liver we are learning and there we will have the answer to the cases of liver suppression, or so called "liver deaths".

In six patients liver suppression seemed the biggest factor but not the only factor in causing death. One writer speaks of the absorption of destroyed liver cells as the cause. I cannot agree with this. The problem in these cases is a derangement of the bio-chemical balance which upset antedates the mechanical surgical procedure and goes on to the fatal termination of a functional type based usually on some histological changes.

To be honest with oneself and willing to accept the responsibility for a death so as to be in that recipient frame of mind which makes one anxious to correct errors is desirable.

In conclusion, the first and largest factor in biliary deaths is the delayed operation which permits of the train of physiological and pathological changes that occur with time's passing. Second, insufficient study and preparation to combat the accumulated pathology. Third, combined operations for complicating and accessory pathology. Fourth, insufficient supportive treatment immediately before and after operation to overcome the handicaps of co-existing pathology. In so far as these factors are eliminated, the results come to be nearer to our desires.

707 RACE STREET.

BREECH DELIVERY

By W. R. BARNEY, M.D.,
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ACCORDING to statistics this presentation occurs in about 30 per cent of all cases, and is only diagnosed before labor in about 50 per cent of them, chiefly because of thick abdominal walls, hydramnios, tumors, and turning of the fetus before the last antenatal examination.

In recent years many articles have been presented on this subject, stimulated by Holland's excellent monograph (1921) in which he called attention to trauma as the chief cause of death, rather than asphyxia as was previously believed.

Fetal mortality due to breech deliveries will be rather difficult to estimate until we have a standard classification, and until then a fair statistical comparison cannot be made of the technique employed by various operators. As it now stands with various corrections made, the average mortality rate for viable babies due to accidents of labor and delivery is about 10 per cent. Studdiford states that the principal factors rendering this so confusing are: (1) Prematurity and macerated babies which accounts for 25 per cent, (2) fetal anomalies incompatible with life (3) placenta praevia complicating breech presentations. In a report concerned with the procedure of delivery surely the above conditions should not be included. On the other hand, prolapsed cord, which is far more common here than in vertex presentations, must be recognized.

The chief cause of death after eliminating the above factors is without doubt trauma to the brain, in most cases brought on by undue haste in delivery. Holland emphasized this in 167 autopsies in which 47 were breech deliveries and 35 of these showed intracranial injury.. He explains this by undue haste in delivery which causes a rapid elongation of the vertical axis of the head which throws a sudden strain on the tentorium with subsequent rupture involving the blood vessels. Corothers in 1923 showed that 88 per cent of stillbirths followed so-called normal breech labors with brain and spinal cord injury the chief causes of death.

Aleck Browne (BMJ-1931) commenting on the causes of death lists these: (1) Intracranial injury, (2) injury to abdominal viscera, (3) asphyxia from cord pressure. He also states that risks are unnecessarily incurred in rapid delivery to prevent asphyxia from aspiration, a result of age long teaching that this is the chief danger. Asphyxia from aspiration is not a great danger, as the mouth and nose is pressed finally against the vaginal wall, but he does warn that too great deliberation in delivering the head may result in asphyxia from cord pressure. His mortality rate was 10 per cent.

A comprehensive report from Guy's Hospital (London) (BMJ—August 1931) of 338 consecutive cases lists as causes of death: (1) Brain hemorrhage as 75 per cent, (2) asphyxia due to cord pressure as the remaining. The former is attributed to hasty and forceful delivery. After eliminating associated complications, a very high mortality rate is reported of 28 per cent in primiparae and 15 per cent in multiparae. These figures are all the more astounding as all cases were very well studied and complete records were available. Their procedure was one of hands off until the breech was born.

R. W. Mohler of Philadelphia, reported 170 consecutive cases with 123 viable babies with 13 stillborn, 11 of which were due to brain hemorrhage.

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He adopts a watchful waiting attitude interfering only when the fetal heart shows embarrassment. Mortality of 10+ per cent is reported.

O. H. Schwarz of St. Louis, (February 1933-SMJ) reported a mortality rate (corrected) of 15 per cent in 1928. In 1931 a report shows no mortality. He attributes this remarkable improvement to close antenatal care, and interfering in the second stage if no progress occurs after two hours. He advises an episiotomy routinely on primiparae, and forceps are applied to the head when any resistance is encountered. Careful preparation of the vagina precedes any operative interference.

Piper, Rassmussen, Irving and Goethals advise routine interference in the second stage, feeling that cord pressure may embarrass the baby. They warn against inexperienced operators attempting this.

In our clinic (Cleveland Maternity Hospital) where all except emergency cases are carefully supervised, and *X*-ray is utilized if there is any question of anomaly such as hydrocephalus, and labor is avoided if any bony disproportion exists, a conservative Caesarean section being the method of choice. The same rule applies in elderly primiparae when a keen desire for a living child exists.

If discovered in the latter months of pregnancy an external version is attempted, using the most gentle manipulation, and no great concern is felt if it is not successful. Most of these cases tend to return to the original position anyhow.

When labor is normal morphine and scopolamin analgesia are used in primiparae, and sodium amytal in multiparae supplementing with ether or nitrous oxide as the second stage appears, occasionally invoking the aid of rectal ether. In case of early rupture of the membranes, a prolapsed cord is ruled out, the fetal heart being observed assiduously at all times. If the first stage is unduly prolonged a Voorhees bag is inserted to aid in dilation, watching for prolapsed cord when it is expelled.

After full dilation has been reached, delivery procedures are instituted as it is in this stage that pressure asphyxia may be encountered. Previous to delivery the vaginal tract is well prepared by manual dilation, as we feel this is one of the most important steps in the procedure. If insufficient room is present we are prone to get extended arms and much resistance in the delivery of the head with the accompanying complications. The same difficulty is encountered if delivery is attempted through an undilated cervix. In addition to manual dilation of the vagina it has been my practice to do routine episiotomies in all primiparae, and I have no hesitancy in employing it in multiparae where any rigidity exists. I feel that this lessens the traction needed and renders less difficult the delivery of the shoulders and head.

The legs are then brought down as double footling, making gentle traction on the legs, allowing the buttocks to descend as it will. If posterior when resting on the perineum it is carefully rotated anteriorly, or into one of the oblique diameters. Abdominal pressure may be given by an experienced nurse or assistant so as to lessen the necessary traction. When the lower border of the scapulae are seen or felt one of the shoulders is rotated anteriorly under the symphysis by gently turning the body, and at the same time using downward traction. The anterior arm usually slips out or can be easily disengaged by splinting the humerous with the forefingers and sweeping the arm out. The posterior arm is delivered anteriorly by reversing the process or may be delivered in situ.

A finger is then inserted in the baby's mouth, the head flexed, and then turned into one of the oblique diameters, the body straddling the arm, with the other hand pressure is made on the aftercoming head with simultaneous traction of the vaginal hand, gently delivering the head to the perineum. When the occiput reaches the symphysis the head is delivered by the Mauricean manoeuver. As the mouth is exposed any mucus present is wiped out and all the necessary time needed is employed as the baby can now breathe. Personally, I have never needed forceps for extraction of the head, but see no objection to their use.

In this series of 550 consecutive cases (1921-1931) deliveries have been made by visiting physicians and house officers, which offers a fair test for the technique employed. All cases were delivered vaginally except 13, in which Caesarean sections were done, four in cases where previous sectons were done, three in placenta praevia, three because of keen desire for living children, one in eclampsia, and one in complete occlusion of the cervix, one in relative disproportion and cervical dystocia with long labor (35 hours).

This series is comprised of 332 primiparae and 218 multiparae, the average length of labor in the former was 15 hours, and in the latter 12 hours. Premature rupture of the membranes seemed to have little effect on the length of labor, for when this occurred the average length of labor in primiparae (148) was 15 hours and 13 hours in multiparae (87).

Deaths from all causes were 104, or 18.9 per cent, but eliminating deaths due to prematurity (53) or 9.64 per cent, and monsters, anomalies and macerated babies (21) or 3.8 per cent, we have a corrected mortality of (30) or 5.45 per cent. Of this number 25 per cent were primiparae and 5 per cent multiparae, showing the former comprising 83.3 per cent of the corrected mortality, a class in which we encounter more resistance in the vaginal tract.

An analysis of the deaths in primiparae show three cases dying from premature separation of the placenta, cases which should be excluded as an

accident of delivery. Three cases died following so-called easy delivery, but postmortem showed cerebral hemorrhage in one. One death was from asphyxia where a prolapsed cord was the causative agent. Nine died after cervical dystocia with the complicating difficult delivery, five of these necessitating manual dilation and seven were in cases of difficult deliveries where the head and shoulders were the impeding factors. Two cases of difficult delivery are in this list where (1) a flat pelvis interfered, and (2) a narrow arch and transverse pelvis offered resistance. Five postmortems were obtained and four showed cerebral injury.

Glancing over this report we see that the chief causes we encountered were those of difficult delivery. Only two episiotomies were done in these cases and I firmly believe a great deal of harm could have been avoided, especially in the seven cases where the head and shoulders were difficult in extracting, if it had been employed.

In the multiparae there were five deaths, one died on the sixth day from an unknown cause, two—24 hours later after so-called easy delivery where postmortem examination threw no light on the cause of death, and one was stillborn, where no cause was stated except that it was three weeks overdue. It seems here, that is, in multiparae, difficulty in delivery has not been a factor, probably due to the greater relaxation of the tissues.

The fact that 83.3 per cent of deaths in primiparae are due to difficult delivery is an impressive fact, and emphasizes the greater tissue resistance in this class of cases as a causative factor.

Review of these cases has impressed me with the facts that: (1) Careful preparation of the vagina by manual dilation is a very important element in overcoming tissue resistance, (2) Delivery through an incompletely dilated cervix should be avoided whenever possible, (3) the more frequent use of an episiotomy, especially in primiparae is a most important factor in diminishing fetal mortality in this type of delivery.

952 HANNA BLDG.

AUDITORY HALLUCINATIONS IN PROBLEM CHILDREN

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THERE has been comparatively little written concerning the occurrence and nature of experiences in the mental activities of children such as have long been recognized as auditory hallucinations in adults. The following reasons are presumed: Definitely psychopathic children in the same sense that adults are often mentally disturbed have not been recognized in very large numbers; there is greater uncertainty in establishing the presence of hallucinations, particularly in young children; the limits of "normal" mental processes in children are not so clear-cut as with adults; the statements of children are not taken so seriously; and finally, what might have been regarded as statements by the child revealing or suggesting the presence of hallucinatory experiences have been construed as simply belonging to the whole picture of his "badness" or "queerness".

This paper embodies notes and observations made by the writer on this subject during a period of about five and one-half years in clinic practice with "problem" children of all kinds.

Recently, the records of 114 children studied in the Cleveland Child Guidance Clinic and 34 at the Central Clinic of Cincinnati, total 148, were reviewed in order to make some observations concerning the frequency of this particular mental phenomenon. These children were all between 10 and 18 years old, this age range being chosen because of the uncertainty of determining and interpreting such experiences as related by younger children. None of these cases had residuals or other evidence of organic brain disease as far as could be determined by physical examination and careful inquiry concerning developmental and medical history. Aside from these considerations, the 148 cases represent approximately continuous clinic intake during a period of about two years. All of these children had intelligence quotients of 70 or more. Some were superior, most of them fell in the normal range of intelligence. Of these 148 cases, 25 or 16.9 per cent, were selected as giving sufficient evidence of having definite auditory hallucinations.

Further discussion of the frequency of auditory hallucinations in children should be had at this point. In our experience with problem children, this phenomenon occurs almost entirely in the seriously withdrawing type whose chief characteristics will be briefly stated below. In a previous paper, "A Study of Some Schizoid Children",[1] auditory hallucinations were noted in 8 out of 19 (42.1 per cent), seriously withdrawing children. At the same time, of 95 problem children of all other kinds, only one revealed such mental manifestations definitely. Such mental exper-

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iences of psychotic significance in "normal" children must, therefore, be extremely rare.

If the seriously withdrawing child is the one principally involved with such experiences, his chief characteristics might be briefly mentioned here. General withdrawing from the usual childish group activities is the outstanding feature. He retreats definitely from the realities of the larger social circle into a world within himself which he can create and manipulate as he desires. Such children are often known as "queer", "goofy" and the like, both to adults and to other children. The phantasy life is particularly rich. Day-dreaming is always excessive and often very profound. A number of themes of phantasy have been found to be developed much more completely than with normal children. These themes have to do with: Unusual wealth and power, death, rebirth, returning to an earlier period of childhood; of being in heaven, in a different world or in a distant country; and of replacing or displacing the parent of the same sex. Often, in this type of child there is excessive reading. In other words these children have to a considerable extent retreated from a practical adjustment to the demands of the real world in which they live. It is not strange to learn also that besides auditory hallucinations, they may sometimes speak of such things as a "dual personality", and "strange influences". While many of them are perhaps schhizoid, few of them have been judged phychotic in the adult sense of the term.

Just as in adults, auditory hallucinatory experiences are best known and occur most frequently, so it is with children that this is the most common variety. Reference, therefore, is not made in this paper to types other than "auditory".

No new theories are advanced here concerning the neuronic, cerebral, psychical or physiological processes involved. With adult so-called functional cases of mental disturbances, one finds in the literature of the last few years, a decided tendency among psychiatrists toward the dynamic philosophy in explanations concerning hallucinations.

Gordon[8] says, "Irrespective of the form of the conscious reactions, the analysis shows that they all have a direct relationship to events, experiences, to thoughts, wishes, ideas, sensations that actually occurred some time in the lives of the patients". Campbell[3] speaks in similar fashion. Noyes[17] states, "It should be borne in mind that hallucinations are not mere matters of chance, but on the contrary have a definite significance in each case. They represent various aspects of the mind, but principally repressed wishes. If their expression were in a frank and recognizable form the patient would be distressed to know that such undesirable and unacceptable trends and desires could be his". Similarly, White[20] says, "Hallucinations represent material more or less frankly, which has suffered repression and which during relaxation or diminution in strength of the repressing forces, has broken through into consciousness. They stand for infantile desires which should have been left behind in the course of development.———"

As to the development of hallucinations, Morgan[15] states, "Often the phantasies take a more firm root than day-dreams do and then the patient may become hallucinated—that is, accept imaginations as fact. When a hallucinated person is found it is not always possible to locate the mental processes which led to this condition, but in some cases the mechanism is so clear that we are enabled to see how one can get into this condition through a development from simple day-dreaming". White[21] speaks of "pseudo-hallucinations—(which) seem to occupy a position midway between imagination and the fully developed form of hallucinations".

When is a mental experience an hallucination? This is a difficult question to answer particlarly when children are being considered. The nature of psychic phenomena in children is generally given a wide range for the normal. The child's inability to distinguish clearly between fact and fancy is usually accepted as a fact. In children as in adults, there is every conceivable graduation of occurrence between what might be regarded as ordinary imagination through a range to hallucinatory experiences without doubt abnormal, even of definite psychotic significance. A further point is that they are not necessarily a sign of serious derangement nor of permanent disintegration.

One important criterion depends on whether or not the child expresses the belief that the "voices" come from sources entirely outside himself and not part of his own mental processes. Distinctness of the "voices" as such is a consideration. Whether or not there are other persons, who may be within voice range at the time helps one in making the decision. This is not an infallible standard because some of our children, for example, have stated they "heard" their teachers saying vulgar and profane things about them in the school room. This, of course, is unlikely. One boy sitting in a rear seat in school said he heard a man behind him inviting him to indulge in certain homo-sexual practices. A girl of 15 "knew" that a certain pupil on the opposite side of the school room was talking about her so that she impulsively went across and struck her. Impulsive conduct of this sort has been taken only as presumptive evidence of hallucinations unless the child came to make a definite statement of "hearing" remarks made in relation to his unusual acts. Statements of parents or others concerning their belief that a given child was "hearing things" can also only be regarded as a presumptive indication unless substantiated by statements from the child.

The brief references to the characteristics of adult hallucinations have been made because much more is known of adult experiences of this kind than those of children. These are subjective experiences whose existence can only be established by the individual's statements concerning them. They cannot be etsimated in any other way. Symptoms of any physical condition are likewise subjective and a child's statements concerning mental experiences may be as reliable as those made concerning a pain in his chest or abdomen. There are certain manifestations of conduct which are presumptive of hallucinations in the child, but these are entirely unreliable. There are acts which are often impulsive and bizarre. He may make accusations that playmates have made slighting remarks and an attack on them may be made without the usual pretexts and events leading up to childish quarrels. Experience leads one to believe that most children who are seriously maladjusted with their fellows, tense, and who show a generally strange behavior, are probably subject to hallucinations, at times, at least. However, the child's own statements, in the confidence of interviews, form the chief basis upon which the material of this paper rests.

A few examples of children's own statements of their mental experiences are given here:

I. S.—white boy—aged 12½. "A shrill voice like a man far away said "You'd better be on the lookout". "I heard a lot of voices swearing and accusing each other of doing dirty things. I think it's me they're talking about, sometimes. I can't repeat what they say. It's too dirty".

V. H.—white girl—15. "It might have been God's voice. It said, 'Be like Joan of Arc and be a savior of mankind'. Once, it came out of the heater. A lot of times it just came out of the air." She assured one her own wishes were not involved. She was sure the "voice" did not come from within herself.

J. R.—white boy—13½. "Doctor, I didn't tell my mother or nobody but you. Why is it when I'm home somebody seems to be saying, 'Why don't you kill your father, the old drunken brute?' I didn't hear it at Detention and I didn't hear it at the Farm School. But when I go home I hear it right away."

R. H.—white boy—12. "I like to be alone because then I can think what I want to. Even then, sometimes, I hear myself being called names like I told you. But I know it could not be anybody so I don't pay any attention".

J. M.—colored boy—10. "Somebody is saying everything about me, like dirty things to my mother. I heard it when I was by myself at home and I heard it when everybody was quiet in the school room. A few times in school I got mad and went across and smacked a boy for saying it. The teacher and him claimed he didn't do it."

R. S.—white boy—16. In the institution where he is staying he thinks others are wiring the doorknobs and bed-springs in order to give an electric shock. "They (voices) say I lost my manhood by doing it (masturbation). Even when I am all by myself 'they' are all the time calling my father 'old Jake' (Jamaica ginger paralysis) and my brothers S.B's."

H. S.—white girl—14. She has long been difficult to manage in the institution where she stays because of undue sex interests. She said quite frankly, "I heard them (voices) for at least three years. 'They' make promises that I hope might come true." "They accuse me of doing things with boys and doing it with other girls and to myself." "I have noticed that when I'm happy for a time I don't hear them. It's when I get along better that I don't hear them".

It has been our experience that the hallucinations and near-hallucinatory experiences in these children have most frequently to do with references to (1) Incest, (2) Sex perversions, (3) Threatenings, (4) Statements of praise or rewards unmerited, (5) Assurances of conditions probably impossible of realization. All of these might well have to do with conflicts contemplation of the nature of which ordinarily would be too painful to conscious thought. The first two are concerned with matters most deeply tabooed by society. The third is suggestive of the child's feelings of insecurity in his social and family groups. The fourth and fifth might be interpreted as of compensatory value to him but the realization of which is a matter of much uncertainty. It may be this considerable separation from reality of the wish implied explains the necessity of expression through hallucinations.

It is the child who is socially isolated in one way or another who most frequently presents these manifestations. Social isolation may be through objectionable conduct or actual separation from one's fellows. Alfred Adler[1] says "This quality which might roughly be called that of the hallucinatory components of the psyche, is more clearly apparent and more easily discerned in childhood than afterwards. . . . . only in those cases where the ego has separated itself from the community and approximates to a condition of isolation are the clamps removed. . . . . We regard the hallucination as the expression of a personality when in a peculiar position."

This fits in very well with our experiences with children having auditory hallucinations. Most, if not all of them, reveal that they are not at ease in association with their fellows. Convcersely, mental experiences approximating hallucinations have not been observed in children whose associations with others of their own sex and age are those which are expected of any child in similar circumstances.

Very frequently, there has been observed a close relationship between the dreams of children and their hallucinations. Often, it is difficult to make certain whether a child is relating a dream, events of phantasy, or describing an actual hallucinatory experience. It is not uncommon for a child to say that in waking hours, he "hears" the same things which occurred to him in a dream.

A question, an answer to which will not be attempted very fully here is, why is such an overwhelming proportion of such psychic experiences

referred to the special sense of hearing? It has been suggested that this may be due to the fact that our thoughts are chiefly verbalized and our communication with our fellows is chiefly by way of the spoken word. Other questions which might be asked at this point are: Why do not hallucinations occur more continuously and constantly than they do? Why do they partake of the particular content and nature which they reveal? Why do they so often clearly have to do with the child's emotional experiences, conflicts and wishes? Why do they so often disappear with a happy solution (for him) of the child's difficulties? It is well known that adult psychotics often become free of their hallucinations in a variable period after admission to a hospital and these reappear in times of unusual emotional stress or conditions of increased complexity of life.

There have been numerous instances in which hallucinations were merely temporary and transient. In fact, the only cases in which such phenomena remained more or less permanently were those of children who were either frankly psychotic when first studied or those whose situations at home or in institution, had long been seriously thwarting and were not improved in subsequent management. The great majority improved at once so far as their hallucinations were concerned when placed in a more emotionally favorable environment.

A little discussion of the technique used in eliciting the occurrence of hallucinations will be given, not in completeness but rather for the purpose of further substantiating the writer's statements that hallucinations actually occur in children. Technique is an important consideration. Asking a child directly, "Do you hear voices?" will in the majority of cases be met by a denial, often indignant, and a cessation of confidences along this line at least. If adults are suspicious of such a question, children are doubly so. In the lay mind, particularly in children, there is probably nothing associated more with being "crazy" than that of "hearing things".

The matter can be approached more successfully and usually without arousing suspicion and resentment, by a more or less extensive preliminary discussion of the child's reading, dreams, daydreams and wishes. Inquiry can tacitly be made as to how real the characters are to him, whether he is one of them, whether he holds conversation with them, and the like. After some such careful and well-laid introduction to the subject, it is not uncommon for a child, particularly an older one, spontaneously to venture a remark to the effect that he hears persons talking to him, calling him vulgar names or saying nice things about him, even when he is alone and no one is near him. It is not usually difficult then to determine whether he refers these "voices" to the outside or regards them as a part of his own natural mental processes. It is to be remembered that one is getting at a highly emotional matter and closely guarded secret. It need only be mentioned, therefore, that the minimum injury to the child's feelings is merely humane, not to mention the matter of future contacts and treatment.

Why try to determine the presence or absence of hallucinations? It is generally believed that definite experiences of this nature do not occur in the mental processes of the normal child. At the same time it is maintained that every conceivable gradation between these extremes may occur. In a crude way, therefore, an estimate can be made of certain aspects of a child's mal-adjustment and the seriousness of his conflicts. The depth and nature of his emotional problems can to a certain extent be determined. If our previous assumptions as to the nature and meaning of hallucinations are correct, we have another avenue of approach to the unconscious comparable to dreams and free-association. If hallucination is an indication of dissociation, it follows that the unconscious problems involved have to do with conflicts which are so painful to the social ideal as to necessitate outlet in other than the usual conscious forms of expression.

Hallucination, therefore, affords one method of estimating the depth of the conflict to the subject. It can therefore, be evaluated to some extent in prognosis. It has been the writer's experience that children are often helped simply through coming to learn why they have hallucinations. There is often a decided relief upon learning that the examiner is not particularly alarmed at their occurrence. Very often there is a relief from the tension of holding in a secret which they dared not tell others. The hallucination often brings into free conversation certain conflicts such as regards incest and sex perversions, which could not easily be brought out in any other way. Often, hallucinations have disappeared as such entirely after a mere revealing of their presence and without attempts to interpret their meanings to the child. It has been the writer's practice to make no more of hallucinations, once the child has come to tell them, than of any other thoughts or mental experience expressed. In fact, it has been a strict rule never to refer to them, even in repeated interviews, as being unusual or abnormal, or even bring them up in conversation with any such implication.

There has been some hesitation in presenting this paper chiefly because of certain rather firmly entrenched attitudes in both lay and professional minds concerning the significance of hallucinations. For many years, the establishing of the existence of such phenomena in a given individual has been regarded more or less as determining a cardinal symptom of a psychosis. In some instances, relating to social workers, teachers and even to physicians, that this or that child had hallucinations has been unfortunate for him in that whereas he had previously been regarded as

a "problem child", he was henceforth looked upon and unwittingly made to understand he was considered "unbalanced". In cases in which the child greatly improved in adjustment and his hallucinations disappeared, doubt was often expressed concerning the earlier observations of the psychiatrist. In other words, there is a profound and general belief that "hearing things" is invariably of unfavorable prognostic portent and permanent in nature.

SUMMARY

1. Some observations have been made concerning the occurrence of auditory hallucinations in children in whom the factor of organic brain injury has been excluded as far as possible. In recent years there has been a growing tendency to interpret such phenomena from a dynamic point of view, that is, auditory hallucinations are regarded as expressions of repressed experiences, wishes and conflicts too painful to the social ideal to be allowed the usual free conscious outlets. In children there is every possible gradation between ordinary thought processes and definite hallucination without any clear-cut demarcation. Such phenomena are not necessarily prima facie evidence of a serious mental condition nor of unfavorable prognostic significance.

2. With most cases in the writer's experience, auditory hallucinations have been transient and have disappeared with a favorable change in the child's life situation. In a study of 148 "problem" children, the occurrence of definite hallucinations has been determined in 25 or 16.9 per cent. All were children having intelligence quotients of 70 or above, and ranged between the ages of 10 and 18 years, younger children not being considered because of uncertainties of the presence of such experiences.

3. The child who is seriously isolated from association with his playmates, either actually or by prolonged disapproval of his conduct, is the type in whom hallucinations have been most frequently present. Definite auditory hallucinations in the more outgoing type of "problem" children must be comparatively infrequent, and quite rare indeed among normal or well adjusted children.

4. Hallucinations have most frequently been characterized by (1) Accusations of incest and (2) sex perversions; (3) threatenings, (4) praise unmerited and (5) promises impossible of realization.

5. The close relationship between hallucinations, dreams and day-dreams has been pointed out. Reference has been made to the importance of a careful technique in eliciting hallucinations from children. In this way an approach can be made to the child's unconscious and another means of estimating the depth of his conflicts is made available. Caution has been urged against allowing the child being unduly impressed that his hallucinations are more than ordinary mental processes similar to his more conscious thoughts. If handled carefully the bringing out of the hallucinations can be utilized greatly in helping the child solve his conflicts thereby contributing to his better social adjustment.

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OSMJ

Dr. Bachmeyer Resigns Deanship

Dr. Arthur C. Bachmeyer, for the past nine years dean of the College of Medicine, University of Cincinnati, has tendered his resignation to the university's board of trustees, effective September 15, 1934. The resignation was accepted. Dr. Bachmeyer will continue his connection with the college of medicine as professor of hospital administration and will continue as superintendent of the Cincinnati General Hosiptal.

OSMJ

At a recent meeting of the board of directors of the American Society for the Control of Cancer, Dr. Burton T. Simpson was elected president; Dr. Henry K. Pancoast, vice president; Dr. J. M. Wainwright, secretary; Calvert Brewer, treasurer; Dr. James Ewing, chairman of the board. The board voted to stimulate interest in and improve *The Bulletin* issued monthly by the society, containing numerous articles on cancer therapy and cancer research. The subscription price of *The Bulletin* is $1.00 per year. A complimentary copy will be sent to any physician requesting it from the society, the headquarters of which are at 1250 Sixth Avenue, New York City.

OCULAR ALLERGY

By A. D. RUEDEMANN, M.D.,
CLEVELAND, OHIO

THE ocular manifestations of anaphylaxis are varied and difficult to elicit. Everyone here is familiar with hayfever, but the purpose of this paper is to draw attention to the many varieties of allergic sensitivity and their diverse ocular symptoms. Otolaryngologists have been treating patients for various forms of irritation of the mucous membranes for years; ophthalmologists, with rare exceptions, have not given the same attention to similar cases. Dr. Allen Woods devotes but little space in his new book to the practical clinical side of allergy, the side that confronts us all in our daily practice, the type of case that is difficult to diagnose and even more difficult to treat.

All who have had any experience with allergy stress the need for a thorough and detailed clinical history of the patient. This is absolutely essential, for often the diagnosis is made on the history alone. Heredity plays a major part in allergy; contacts; environment, habits, medication, plants, foods and other factors must also be considered. The management of cases of ocular allergy is difficult, but not impossible. There are many allergic manifestations in the eye, many more than we ever supposed, and it is necessary that we who are practicing ophthalmology realize the range of possibilities in this type of case, and investigate the problem thoroughly.

Over a period of years, I have been interested in vernal catarrh and follicular conjunctivitis and it was through special study of these two problems that the frequent occurrence of other local manifestations of general allergy was made apparent to me. In many of these cases, the symptoms are confined solely to the eye; it is not necessary for the condition to be in evidence elsewhere in the body in order to be certain of the presence of an allergic process.

The reactions of the external eyelid are similar to the skin reactions caused by certain irritants elsewhere in the body. The lids, however, are extremely sensitive—they approach mucous membrane in this respect—and react more violently than does ordinary skin. Any fumes, chemicals, extremes of light, heat or cold may cause a mild to severe local reaction. The condition in some instances is so severe as to cause fissuring of the lids and lid hypertrophy. Hair washes, face creams, face powders, especially those containing orris root, eye lash treatments such as mascara, and lip stick, are frequent causes of local irritation. The local treatment is a mild ointment, such as a 3 per cent ammoniated mercury, dry cold compresses (no water should be used around the eyes) and removal of the cause by discontinuing the use of the primary irritant. The patients thus affected are numerous and are grateful for the relief from the itching and edema about the eyes.

Both blepharitis marginalis sicca and blepharitis ulcerosa often are caused by some sensitivity. The siccus type is usually seen in conjunction with dandruff and some other scalp condition. The ulcerous type more often is due to a food sensitivity and the tests for various proteins, either by the scratch, intradermal or conjunctival method usually are necessary to make a correct diagnosis. Local treatment consists in the application of a mild ointment, with massage to the lid margins, and restriction of the diet to eliminate the offending food. I have seen a striking case of blepharitis ulcerosa in a man with a twenty-two year history of treatment of the lids with remissions and recurrences. The patient was found to be extremely sensitive to oranges and tomatoes, both of which were a large part of his diet. Within a week after the elimination of these foods, the condition cleared up and he has now had no trouble for over eighteen months.

Patients with chalazia recurring over a period of years are very likely to show some allergic sensitivity and respond extremely well to the elimination of faulty foods from the diet. Patients with hay fever are likely to have chalazia and many present themselves during the spring and fall seasons in an acute condition. Although it has been impossible to prove that allergy is a common cause for styes, I have treated a boy who gets a stye within forty-eight hours after the ingestion of chocolate, to which he is extremely sensitive. He gets a severe headache after ingesting any food containing chocolate.

The palpebral conjunctiva is the most common site of allergic inflammation. Sunlight, heat, and cold—the so-called physical agents—are not uncommon causes of a low-grade follicular type of conjunctivitis. Smears and cultures from these patients usually are negative. The sunlight group are helped by a visor, glasses, usually II or III shade, cold compresses and increasing doses of sun. One case of this type was that of a boy, who, over a period of years, had restricted his summer activity to going from a semi-dark room to the shade of a tree in the garden. A patch test with roentgen-ray elicited extreme hyperemia. Further questioning brought out the fact that he had suffered much discomfort at one time while receiving treatment for a broken arm. Such patients are sensitive to light, have much photophobia which may be present in the winter with a new snow on

Read befre the Eye, Ear, Nose and Throat Section, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7-8, 1933.

a sunny day, as well as in the summer, and they must be treated throughout the year. I have treated a group of six patients of this type who are now quite comfortable. The local lid condition often is accompanied by retinitis, rather hyperemia, which undoubtedly is the cause of the photophobia. The lachrymation in patients with palpebral symptoms is extreme and may cause fissuring at the external angle. They are very uncomfortable with the burning and itching and the feeling that there is sand in their eyes. They rub their lids and increase the inflammation.

On the whole, the group of patients with follicular conjunctivitis is more likely to show a seasonal periodicity and usually falls in the class with true hay fever. This includes a large group and the season for them may commence with the tree pollen in early spring and carry on until late in the fall. A mild astringent, zinc and adrenalin solution and holocain and adrenalin ointment, cold compresses, dark glasses and vaccines or elimination of irritants, when necessary, are usually sufficient to control the symptoms. Irritants such as silver nitrate and argyrol are of no avail and are definitely contraindicated.

The follicles in follicular conjunctivitis and in vernal catarrh usually are large and most plentiful along the mesial and lateral aspect of the inside of both upper and lower lids; the area between has much smaller and more sharply pointed follicles.

Vernal catarrh may or may not be evidence of allergy, but I have treated three patients with vernal catarrh. The first had been treated for trachoma, and the others had been treated with radium. All three of these patients finally responded to treatment for allergy. The first received vaccine, the second, food regulation and the third, sunlight treatment. These cases are the most distressing and difficult to prove and treat, and require unlimited patience and effort on the part of the allergist. The true condition of one boy finally was proved by intradermal tests. I am aware of the fact that a large series of cases of this type has been reported with approximately 50 per cent negative reactions. All three of the patients just metnioned gave negative responses to tests for years, but finally, with continued search and treatment, it was possible to trace the cause. Much more investigation on this subject is necessary but allergy is a logical cause of vernal catarrh and I believe that this will be confirmed by continued careful study.

Several years ago, I stated in a paper the common findings in hypometabolism of itching of the eye lids, with scratching and burning, convergence weakness and lid edema. I wish to repeat this with the added comment that attention has been drawn to this by others and that recently, in going over a group of cases of myopia, the occurrence of hypometabolism and allergy was extremely frequent, sufficiently so to make me plan to study the same group for these points alone.

Corneal conditions are not common, but a good many instances occur in infants or young children. The so-called eczematous keratitis, usually caused by milk, is an allergic problem. Many of the phlyctenular ulcers are allergic and there is a low-grade chronic form of superficial keratitis which rarely invades the substantia propia but may completely cover the cornea with a greyish membrane. In five cases of this type, definite causes were found in food or pollens, one of these in a chemist, exposed to gasoline fumes, and one in a four weeks old baby with marginal keratitis, due to milk.

The relation of allergy to intra-ocular pathology is more difficult to elicit and to prove, but personally, I feel that chemical reactions of the body must explain some of the dissolutions seen within the eye. In one striking instance a patient with neuroretinitis was referred to me because of loss of vision, and the question of possibility of a brain tumor had been raised. No intracranial pressure was found and further questioning revealed a pollen sensitivity. The boy's vision improved with the disappearance of the edema, but he has had several minor recurrences during the hay fever season.

I have not attempted to give a detailed discussion of ocular pathology. I do not believe any tissue is immune to chemical sensitivity. I believe the field of allergy offers a logical and interesting explanation for many recurring lesions. To study these cases, one must have the complete cooperation of a good allergist who has the time and patience to work out the problems. The ophthalmologist must be fair in the interpretation of the findings and must assist in the treatment, for these patients seem to be more prone than others to laxity in following their diets and other treatment.

SUMMARY

1. Allergy is a frequent cause of eye disease.

2. Allergy is the usual cause of follicular conjunctivitis.

3. There are numerous other local manifestations in the eye which may or may not be associated with some allergic condition.

4. Treatment must be instituted and followed both by the allergist and by the oculist, for it usually requires the efforts of both to get the patient to cooperate properly.

EUCLID AVENUE AT 93RD STREET.

DISCUSSION

A. D. FROST, M.D., Columbus: The medical profession in recent years has been hearing and reading about allergy mostly from the research laboratories but its clinical application has not been properly appreciated. I am quite sure that Dr. Ruedemann's paper will stimulate more thought in this direction and more action on our part from the therapeutic standpoint. Every specialty perhaps encourages much enthusiasm

on the part of its practitioners and the allergist may be inclined to attribute most diseases to his field. It behooves the ophthalmologist however to be alert to the importance of allergic phenomena in his practice but not to the exclusion of our other fundamental knowledge of ocular disease.

Focal infection is always uppermost in our minds in the analysis of endogenous ocular inflammation, but the true mechanism by which it is produced is not understood. The theory that a transient bacteriemia causes the lodgement of organisms in the various ocular tissues was an easy interpretation but research workers have sought in vain for the most part, to cultivate the same organism from both primary and secondary foci. We are all cognizant of the fact that we do observe marked therapeutic improvement in many ocular inflammations after the removal of distant foci of infection, but in many instances we fail. Recurrent inflammations of the *same nature* are often observed in the administration of an autogenous vaccine and such flare-ups indicate specific sensitivity to the bacterial products from remote foci. The best clinical proof we have that many ocular inflammations are allergic is that proper desensitization results in clinical improvement in the eyes.

In our routine practice we must constantly be on the alert for allergic manifestations. Too frequently we pass these cases by with only local or symptomatic treatment, particularly the cases of follicular and chronic types of conjunctivitis and blepharitis. Temporary improvement in these cases may be effected more by the lucky avoidance of the offending allergin than by the collyrium prescribed. Permanent cures however are more often the result of painstaking efforts to discover the specific allergin.

The best treatment for the hay fever sufferer is to go to a locality where he can avoid the specific pollen but our problem in allergic eye diseases is to give the patient adequate treatment at home. As has been said this sometimes is a very painstaking and seemingly hopeless task but there is no phase of ophthalmology which offers such promise from the standpoint of clinical therapeusis. The type of treatment is therefore self-evident and consists of the removal of the specific allergin as far as possible and the desensitization with the responsible allergin.

PUBLIC HEALTH WITHIN THE HOSPITAL

By H. L. ROCKWOOD, M.D.,
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JUST as a routine technique is set up providing asepsis in the care of surgical cases, every hospital or institution caring for the sick should provide a medical aseptic technique to be routinely followed by hospital personnel in fully as rigid manner, but modified or adapted to meet the specific requirements of the various forms of contagious and communicable disease certain to be encountered from time to time among patients, personnel, or visitors.

The close association of patients with other patients, with the hospital personnel, and with visitors; the greater hazard of serious consequences when those already ill from other causes become victims of acute or chronic infections, together with the lowered efficiency of the service rendered by hospitals resulting from the necessity of segregating patients and quarantining wards, are sufficient reasons for urging careful attention to the subject of medical asepsis in hospitals as applied to the prevention of and protection against transmissible diseases. It is proposed to here briefly discuss the underlying public health principles which should be used in setting up regulations for the control of these diseases in institutions. The objectives sought in such public health principles of hospital operations may be classified into three general groups.

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Director, Mount Sinai Hospital of Cleveland.

The first objective seeks the prevention of primary cases of communicable disease within the hospital, except as diagnosed on admission among patients requiring hospital care, and when so admitted, placed immediately under the precautions set up as a part of the medical aseptic technique of the hospital for the protection of the public health. The successful accomplishment of this important objective requires a well planned technique of this character carefully followed by both the administrative and the professional personnel.

The second objective where the application of public health principles is required also carries both administrative and professional responsibilities on the part of the personnel. This objective seeks to prevent the occurrence of secondary cases of communicable disease arising from a primary case when diagnosed among patients, personnel, or visitors.

The third objective which must not be disregarded aims to prevent transmitting disease by combining prophylactic safeguards with therapeutic measures employed when indicated from the standpoint of public health in the professional care of cases. In this group are included the measures used to prevent such diseases as rabies when cases of bites from dogs or other animals subject to this disease are brought in for emergency care.

Early cauterization with fuming nitric acid may do as much to prevent rabies as the more specific treatment by means of rabies virus. The use of tetanus anti-toxin as a routine measure in caring for punctured or soil contaminated wounds is another example of the

prophylactic safeguards of this character as well as are measures employed to prevent the transmission of disease in the use of fresh blood or blood sera, as in blood transfusions or in the use of convalescent sera.

Each of these three public health objectives, adapted to the methods of transmission of the numerous communicable diseases, comprises a general group of protective measures, and for greatest success in their application much depends upon the weight given to three important considerations.

The first of these considerations should be given to how seriously the occurrence of the various communicable diseases is anticipated. The average age among members of the hospital personnel in training, such as student nurses, or young graduates in medicine, who must be depended upon to follow regulations of medical asepsis against contagious and communicable diseases, is too young to have experienced at first hand some of the situations common a few years ago when small-pox, typhoid fever, and diphtheria were diseases much more prevalent. The low incidence of these diseases at times tends to lower among the younger generation of doctors and nurses of the hospital personnel, the serious regard held for them by older members among the attending staff, or by older nurses who have been through epidemics of these diseases.

It is evident that security from communicable disease in hospitals can only be inferred when those susceptible to these diseases are absent. While immunity, when present, serves to prevent the outbreak of such diseases, there is no likelihood of restricting patients, personnel, or visitors, to those who are completely insusceptible to all dangerous communicable diseases. At the same time there is sufficient general prevalence of both acute and chronic dangerous communicable disease to warrant the continuous anticipation of primary cases of these diseases within hospital walls unless and even when a comprehensive technique directed against them is set up and routinely used. Their incidence particularly with regard to secondary cases will depend to a great extent on this point of how seriously they are anticipated.

In all three of the public health objectives mentioned, namely, the prevention of primary cases, the protection set up against secondary cases, and in such protective therapeutic measures as affect the management of dog bite emergencies, punctured or soil contaminated wounds, and in the use of fresh blood or sera frequent in hospitals, a serious regard for transmissible disease as not a remote or inconsequential possibility remains a fundamental public health principle which should never be disregarded. The practice of this principle on the part of staff members and those who set the pace for younger members of the hospital personnel will result in an alertness on the part of all for the incidence or occurrence of these diseases. As a part of the medical aseptic technique set up there will be a competent inspection of patients immediately upon admission and before they are allowed to enter open wards or rooms with other patients.

The qualifications of the medical examiner for this safeguarding of the public health will be duly considered. Young house officers without much contagious disease training may not be well qualified for this important duty, and for this reason senior house staff men will be chosen for the duty of promptly seeing all new admissions when possible, or sufficient facilities for holding cases in isolation on admission until seen by a visiting physician will be provided. The experienced examiner will not overlook the importance of eliciting from patients or from those knowing the home conditions any history of recent exposure to contagious diseases. He will not be misled to admit without precautions such conditions as acute mastoiditis, sinus infections, or suppurating glands, often demonstrated at great inconvenience to the hospital to be sequelae of scarlet fever, of recent origin for which no physician may have been called or which the referring physician may have accepted for care without knowledge of the antecedent contagious disease. Acute appendicitis will be looked upon, until definitely known to be otherwise, as a possible abdominal manifestation of a generalized infection which may also be present affecting other lymphoid structures thus masking such communicable diseases as typhoid fever, scarlatina, or acute tonsillar conditions.

At this point it is not out of order to refer to instances not rarely occurring in past years where virulent smallpox due to the comparative rarity of this disease among vaccinated populations, and the similarity of its onset to other more frequent diseases, has been admitted to hospitals for care with such mistaken diagnoses as influenzal pneumonia or purpura hemorrhagica. An alertness for the occurrence of dangerous communicable diseases will cause to be included as part of the medical aseptic technique the routine use among the hospital personnel of well proved methods of immunization such as vaccination against smallpox.

The second consideration on which the public health objectives of hospitals depend for success relates to the degree of speed or promptness with which the regulations governing medical asepsis are put into effect. There is an analagous relationship of measures used in preventing the spread of communicable disease to the methods employed in fire protection. Speed in both instances is of paramount importance in the use of control measures. Prompt detection with prompt restrictive measures are the underlying public health principles to be followed. The setting up of a routine technique to be followed so that the hospital personnel may be thoroughly

schooled in advance of the occasion when its use is indicated is urged largely to expedite the use of these measures whenever the need arises. The speed with which primary cases are detected, isolated, and precautions set up to prevent further exposure of susceptibles, is a measure of efficiency as regards medical asepsis.

The practical application of this principle of promptness or alacrity as applied to the prevention of secondary cases calls for a carefully planned set of regulations governing isolation precautions, and concurrent as well as terminal disinfection. Due to the fact that precautionary measures differ with the various forms of communicable disease involved, the regulations drawn up governing isolation precautions may be conveniently set forth as "types" or classes. For example, Type "A" precautions will be the set of regulations to be used in such disease as smallpox, scarlet fever, or measles, Type "B" precautions will be those precautionary regulations applicable to such diseases as typhoid fever, while Type "C" precautions will provide the needed protection against such diseases as pulmonary tuberculosis, or certain forms of syphilis.

Each one of these so-called types of isolation precautions requires specific provision for the kind of isolation as regards the location of patients, whether to be in a single room, a cubicle, or ward, and the protection required of those in attendance or entering the environment of the patient in regard to the wearing of masks, gowns, gloves, and the cleansing of the hands. Each type should also make due provision for the proper care of contaminated linens, garments, and gloves if used. Provision must also be included for the proper handling of utensils, thermometers, bed pans, the use of sputum cups as needed, the sterilization of dishes, trays and contaminated linens, and all measures usually known as the technique of concurrent disinfection. Finally, terminal disinfection of the room, furniture, bed, and bedding must be detailed. A recent paper by T. R. Ponton[1] deals with these details in a manner which can be highly recommended for establishing a system of medical asepsis in the handling of communicable diseases in general hospitals.

With such a set of isolation precautions in effect as approved by the medical staff and well understood by doctors, nurses, and service personnel, much time is saved when occasion arises in getting cases requiring precautionary measures under proper control, and orders may be written for the desired type of isolation precautions with such modifications as the case may require without rehearsing and cataloging on the order books all of the numerous procedures necessary. The consideration of promptness as a principle to be followed in the public health objectives of hospitals should not be left without applying this principle to the notification of and cooperation with public health officials.

It should be borne in mind that at the moment of diagnosis of a communicable disease the patient affected becomes subject to the public health laws relating to these diseases, and that those who have professional control of the patient are responsible to the State usually through the local health department regarding notification as well as for adequate isolation against the spread of these diseases. While it is obvious that patients excluded from admission when contagion is diagnosed by the alert admitting examiner should not be merely told to go or be sent home without regard to the exposure of others in street cars or otherwise on the way, and of other members of the family when they arrive at their destination, still it is a fact that the public health conscience is sometimes not well enough developed to prevent this violation of the proper technique in handling cases of diseases dangerous to the public health.

The third of the three important considerations for accomplishment of these public health objectives of hospitals concerns the facilities available within the hospital for observing medical asepsis against communicable diseases. Isolation rooms with running hot and cold water for hand disinfection, soap dispensers of proper type, sterilizers for utensils and dishes, when not available, are sure to put at great disadvantage the accomplishment of these objectives. Laboratory facilities are essential as a means of confirming diagnosis of suspected cases of the communicable diseases as well as for the prompt exclusion of syphilis among blood donors when blood transfusions or convalescent sera are required. Polayes and Lederer[2] refer to many instances where syphilis has been transmitted during blood transfusions. The Cleveland Hospital Council has recently recommended that "hospitals use the additional precaution of cross-matching donors cells against patient's serum, perform a precipitin test to exclude possibility of syphilis having been acquired since Wassermann was performed, and additional physical inspection by member of hospital staff before performance of transfusion". A similar use of this rapid test for syphilis is indicated at times on obstetrical wards.

Equipment of suitable character is often lacking for heat sterilization of contaminated linen, mattresses, pillows, and of excreta. Chemical disinfection of these items by means of chlorinated lime or formalin is at best a poor substitute for heat. When used, some definite formula should be adopted as described by Ponton[1], and it is important to have available suitable containers large enough to permit the use of adequate amounts of solutions. There is also a need for having available infirmary quarters for members of the personnel who live within the hospital as in the case of student nurses, where those susceptible who are inadvertently exposed to contagion may be isolated during the incubation period. Such quarters must have separate bath

room and toilet conveniences. While these facilities are often found to be overlooked in hospital construction it is usually possible to assemble the needed items of equipment and provide the required isolation beds when the setting up of an adequate and comprehensive system of medical asepsis against communicable disease is undertaken.

Among pediatric cases and the newborn on the maternity ward, certain special measures of protection are required. Children and infants comprise the greater group of susceptibles to most of the common contagious diseases, and while these diseases are frequently encountered among adults, the pediatric staff will usually require somewhat more specific safeguards against contagious diseases on pediatric wards and in the nursery. The regulations written into the statutes regarding the protection of the eyes of the newly born is an example of specific requirements, aimed primarily at gonococcus infection in this instance. When dealing with suspected or frankly diagnosed diphtheria, for example, measures of protection will differ from those when a case of measles is discovered.

The emphasis is to be placed upon the need of having a technique planned in advance and ready for use when occasion requires. Spencer[3], for example, has outlined procedures to be followed in general hospitals among exposed patients when cases of measles arise. He stresses the importance of prophylactic treatment promptly employed especially among children under five because of high mortality in measles among this age group. He suggests that protection against or modification of a threatened attack of measles in susceptible contacts lies mainly in the administration of convalescent, parental, or adult serum, and reports that in 3721 patients inoculated before the eighth day 434 developed modified, and but 50 unmodified attacks of measles, an incidence of 11.6 per cent of modified cases, and of but 1.07 per cent unmodified measles.

Among young children already seriously ill, the protection thus afforded to measles should have our serious consideration in advance of cases almost certain to develop unexpectedly or expectedly depending upon the use of public health principles which have been already outlined. Here again the needed alertness for the appearance of the primary cases, the promptness with which control measures are instituted, and the availability of needed facilities for medical asepsis, including the availability of the needed prophylactic sera, serves to illustrate specifically the preceding discussion of the public health objectives within the hospital, and the factors which enter into the establishment of a satisfactory technique.

In conclusion, hospitals should set up a technique in medical asepsis for the prevention and control of transmissible diseases just as in the care of surgical cases an aseptic technique is generally employed and routinely followed. Naturally, the medical staff will carry the responsibility of making or approving such regulations and must cooperate with the administration in their application to the three public health objectives of hospital operation, namely the prevention or the early detection of primary cases of communicable disease within the hospital, the prevention of secondary cases therefrom, and the prevention of disease by specific prophylactic treatment when indicated as in the prevention of rabies and tetanus and by the use of precautions against the transfer of communicable disease when fresh blood or blood sera are therapeutically employed.

Success in each of these objectives will be influenced greatly by the degree of alertness among personnel for the incidence of communicable disease, the speed or promptness with which control measures are employed, and the facilities available for diagnosis, detection, isolation, and protection needed for an adequate system of medical asepsis against communicable disease within the hosiptal.

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OSMJ

Goiter Group Plans Meeting

American Association for the Study of Goiter will hold its annual meeting, June 7-9 at Wade Park Manor, Cleveland. The morning of the first day will be devoted to clinics at various Cleveland hospitals. On the afternoon of June 7, addresses will be delivered by Dr. Stuart Gordon, Toronto; Dr. Urban Maes, New Orleans; Dr. H. M. Clute, Boston; Dr. Edward H. Rynearson, Rochester, Minn.; Dr. Samuel Haines, Rochester, Minn.; Dr. Henry K. Ransom and Dr. Robert H. Bayley, Ann Arbor, Mich.; and Dr. W. F. Rienhoff, Jr., Baltimore. On Thursday evening, there will be addresses by Dr. Herman L. Blumgart, Boston; Dr. L. J. Karnosh, Cleveland, and Dr. R. M. Howard, Oklahoma City, president of the association. Speakers on the program for June 8 will be: Drs. Arnold Jackson, Madison, Wis.; H. L. Foss, Danville, Pa.; Claude J. Hunt, Kansas City, Mo.; Julian Johnson, Philadelphia; George M. Curtis, Columbus; George W. Crile, Cleveland, and Professor Francis H. Herrick, Cleveland. The meeting will be concluded with clinics on June 9 at the Cleveland Clinic.

OSMJ

Portsmouth—Dr. H. G. Southard, state director of health, addressed the local Lions' Club on "The Advancement of Medicine During the Past 50 Years".

BROMIDE INTOXICATION

By G. T. HARDING, Jr., M.D.
AND GEO. T. HARDING, III, M.D.
COLUMBUS, OHIO

THE purpose of this paper is to call attention to the fact that bromides, even in therapeutic doses, may produce mental symptoms in susceptible individuals. These symptoms range from a mild clouding of consciousness to an active delirium, and from emotional and intellectual depression to stupor and coma.

The importance of the subject is evident when one considers the widespread use of bromide in the treatment of the nervous and mildly neuropsychiatric patient. Most of the patent medicines and nostrums advertised to a susceptible public and often used by the less discriminating physicians, contain bromide as the potent drug, although it seldom appears on the label.[1] Represented as safe and harmless nerve tonics for insomnia, nervousness, and nerve exhaustion, they are taken without due regard to dosage by the same neuropathic and socially maladapted group who depend on alcohol and other drugs to escape reality. It is necessary only to mention the dependence that is placed on bromide in the convulsive disorders.

INCIDENCE

The frequency of bromide intoxication was first emphasized by Wuth[2] in 1927, when he found 20 cases in 238 admissions to an epilepsy clinic. Wuth's article and his simplified comparator for rapid and accurate estimation of the blood bromide, stimulated interest in the condition. Wagner and Bunbury[3] in 1930, reported 1,000 consecutive admissions to the Colorado Psychopathic Hospital, and found an excess of bromide in the blood of 7.7 per cent of the patients. Of these 77 cases, 44 or 4.4 per cent of the total admitted were found to have mental symptoms due to bromide intoxication. Levin[4] reported 15 unquestionable cases of bromide psychosis in 505 first admissions to the Harrisburg State Hospital, an incidence of 3 per cent.

Our own series comes from a private sanitarium for nervous and mental disorders. Probably half of our patients would be considered "nervous" rather than "mental", and would not be found among the admissions to state hospitals. They are doubtless representative of the types of nervous and mental patients met in general practice.

In 405 consecutive first admissions from January 1, 1931, to December 31, 1933, there were 77 cases, or 18.8 per cent which fell in the toxic or exhaustive-confusional group, such as the acute intoxications by drugs and alcohol, as well as the acute confusional states after childbirth, surgery, and somatic diseases. Of these 77 cases, 18 were found to have symptoms and laboratory findings indicating a bromide intoxication. These 18 cases represent 4.4 per cent of the total first admissions and 23.4 per cent of the acute confusional group. The importance of considering bromide is evident when confronted with an acute toxic-confusional patient, and especially so when one realizes that probably 50 per cent of this group in our series were easily recognized as alcoholic.

SYMPTOMS

The toxic effects of the continued use of bromide other than on the higher psychic levels are well known. The coated tongue, "bromide breath", dull headache, constipation, disinclination for either physical or mental exertion, and psychic depression are recalled. The appearance of acne during bromide administration is usually relied on as a warning sign, although only three of our eighteen cases had any eruption. The acute confusional states resulting from bromide intoxication have been overlooked until recently, although isolated cases have been reported for over 50 years. The chronic bromide depression and cachexia with mental deterioration, ataxia, and emaciation were known to improve rapidly when bromide is withdrawn, and have usually been recognized by the attending doctor.

The acute confusional state due to bromide presents a variety of clinical forms. They resemble other acute organic or toxic reactions such as those caused by encephalitis, uremia, alcohol, and other drugs. The long continued use in elderly patients may develop the clinical picture of a senile or arterio-sclerotic dementia. One patient seen in consultation had been returned from California at a considerable expense with a special nurse. Her mental symptoms had developed after she had fractured her leg and bromide had been prescribed to quiet her. The apparent dementia of six months' duration promptly disappeared when the bromide was withdrawn.

Neurologic signs accompany the mental symptoms in many of the cases. Sensory impairment results in the loss of the corneal and palatal reflexes. The pupils are often irregular or unresponsive to light. Extraocular imbalance results in diplopia. The speech is slow and thick. The deep reflexes may be decreased or increased, but the abdominal responses are usually absent. Tremors and ataxia are also seen, and incontinence or "excreta careless" occurs in the stuporous patient.

The intoxication proper can be divided into three clinical varieties. Although individual susceptibility and other factors interfere to prevent any accurate correlation between the toxic symptoms and the bromide level of the blood, our experience and convenience warrant such a division. The

normal blood serum does not contain an appreciable amount of bromide. Symptoms have not occurred in our experience where the blood bromide fell below 100 mg. per 100 cc. The effects where the blood bromide ranges from 100 to 150 mg. per 100 cc. warrant the classification of a depressive stage. The symptoms may be limited to a mild depression, signs of increased irritability, an emotional instability, and transitory mild confusion. With a concentration of 150-300 mg. per 100 cc. the symptoms are apt to be those of an irritative state—confusion, hyperactivity, and hallucinations. Above 300 mg. per 100 cc. the patient often becomes more or less stuporous—his activity, both physical and mental, is at a minimum and the neurologic signs referred to appear. However, certain individuals seem to feel no ill effects of even the higher concentrations.

CASE REPORTS

CASE I—Summary: Bromide intoxication as a post-operative complication.

Male, age 56, seen in consultation February 15, 1932, because of increasing confusion, disorientation, and hyperactivity complicating convalescence from right leg amputation January 20, 1932. Moderate doses of morphine, codeine, and nembutal had been used to control post-operative pain, but substitution of bromide was begun on the third day. The daily dose never exceeded 60 grains. The total amount of bromide administered was 702 grains.

Depression and irritability were described on the nurse's chart five days after beginning bromide medication. On the eighth day he had lapses of memory, and got out of bed, but did not recall it when clear later in the day. On the twelfth day became overactive, disoriented, and wanted to go to his office. By the twentieth day he was stuporous at times; euphoric rather than depressed and emotional; vasomotor disturbances appeared.

When first seen he was confused and disoriented to the extent of misidentifying members of his own family. He saw people in his room, spoke to them, swore at them, became highly excited, and alternated between depression and euphoria. When not disturbed he dropped into a sleep.

Bromide intoxication was suspected. The following day the blood bromide was 350 mg. per 100 cc. Bromide was withdrawn and the overactivity and hallucinations increased. At times he saw gunmen at his window and tried to escape. Miniature dancing girls performed on the mantel. Large animals crossed the room. His wife was drowned in a glass case in the corner of the room; his daughter was brought in to see him in her coffin. Children played in his drinking glass. He welcomed guests to a reception with elaborate gestures. During a lucid interval while being told the nature of his confusion, he turned the sheet down and apologized, "I know there aren't any fish there, but I have to look to be sure I don't see them."

The mental symptoms completely disappeared on the 23d day after withdrawal of bromides. The blood bromide was 150 mg. per 100 cc. the day before.

CASE II—Summary: Bromide intoxication from self-medication for insomnia.

Male, age 66, brought to hospital August 31, 1932, by two male attendants who had been required to control his activity and resistance at home. Had been in ill health several years, but began acting queerly several weeks before admission. After recovery told of using bromide to produce sleep.

Blood bromide 375 mg. per 100 cc. when admitted. Was ataxic, speech slow and thick, disoriented as to time, place, and person, although lucid at intervals, stuporous, but when aroused, excited and noisy because of hallucinations. Saw faces at the window, thought he was spied upon, called his mother, saw diminutive girls dancing on his bed, draped sheet about him and impersonated a lodge dignitary; small and large animals paraded about him.

Blood bromide 300 mg. per 100 cc. after one week. Became less stuporous, still thought he was home, insisted the male nurse was an old friend. Toward end of week began to have insight and wanted to know what had happened.

Blood bromide 200 mg. per 100 cc. after two weeks. Still restless but not confused, interested in appearance, hypersensitive. Became oriented, but also unreasonable and irritable. Depression and mild anxiety replaced the euphoria.

Blood bromide 125 mg. per 100 cc. after third week—40 mg. per 100 cc. after fourth week. Physical improvement rapid; ataxia partly due to alcoholic neuritis disappeared, together with insomnia, and after about three months felt better than he had for years.

CASE III—Summary: Bromide intoxication complicating its use for nervousness and insomnia.

Female, age 60, admitted to hospital February 13, 1932, because of erratic conduct at home. Had become excited, hallucinated in both visual and auditory fields. Similar behavior two months before had led to hospitalization, where she insisted she was at term, that her daughter was dead in the next room. Returned home suffering from insomnia, nervousness, and depression after four weeks in hospital. Bromide medication resumed with return of mental symptoms.

Blood bromide 225 mg. per 100 cc. Cooperative most of the time, but threatened suicide and refused nursing attention frequently during first few days. Was dizzy and slightly ataxic, but neurologic signs were absent. Memory and association faculties poor. Blocking frequently occurred, also neologisms.

Blood bromide 125 mg. per 100 cc. on twelfth day, when confusion and disorientation finally disappeared. After four weeks her physical condition was much improved, but she was still mildly depressed and emotionally unstable. Gradual but complete recovery followed at home.

CASE IV—Summary: Bromide intoxication superimposed on chronic alcoholism.

Male, age 40, a heavy drinker, was given a bottle of bromide-barbital mixture containing 1920 gr. bromide and 16 gr. barbital by his doctor to help him sober up. He took it all during the course of five days. On the fifth day he became confused, ataxic. Although no more drugs were given, his delirium increased.

Admitted to hospital January 17, 1931, delirious, ataxic, helpless, and at times stuporous and incontinent, just eight days after the first dose of bromide-barbital. Neurologic findings included unequal, sluggish pupils, superficial reflexes obtunded, deep reflexes increased. The blood bromide was 350 mg. per 100 cc.

For ten days he was disoriented, saw mice running up his pants leg, a duck in the bed, and felt water poured on him by his tormentors. Refused

to eat because he suspected he was being poisoned. Became violent in his attempts to escape. On tenth day became lucid, wrote a letter to his mother, but after several hours snakes appeared in his bed. On the fourteenth day the mental symptoms disappeared and did not return. Blood bromide 100 mg. per 100 cc. on that day.

CASE V—Summary: Bromide intoxication complicating Bromoselzer addiction with underlying schizophrenia.

Male, age 37, was stuporous, cyanotic, respirations 36-40, temperature 103° when admitted to the hospital September 19, 1932. Routine blood bromide determination revealed a content of 400 mg. per 100 cc. The only source of bromide was Bromoselzer, of which he took "as many as twenty big shots a day", which also explained the marked cyanosis.

The stupor continued for three days. With return of mental awareness he became restless, noisy, and completely disoriented. Speech slow, thick, and incoherent. On the fourteenth day he became oriented, showed fair insight, with a blood bromide of 250 mg. per 100 cc.

For several days he improved, showed an active interest in things, then began to be depressed, disinterested, but oriented and coherent. A schizophrenia was recognized, and he was taken home because his family would not consent to certification. Two weeks later he committed suicide.

CASE VI—Summary: Bromide intoxication resulting from use of epilepsy cure with assumption of low-salt diet.

Male, age 67, had been taking the Converse treatment for twelve years after several major convulsive attacks, with only petit mal since beginning treatment. He took a daily dose of two to three teaspoonfuls religiously, and was regular in his habits. Several months before consulting us he came to visit a daughter who cooked without using salt for seasoning—a practically salt-free diet. Soon he began to have headaches, dizziness, weakness, and became mildly depressed and emotional. The blood bromide was 225 mg. per 100 cc. Phenobarbital was substituted and his symptoms disappeared. The absence of salt in his diet broke the equilibrium between the intake and output of the bromide in his medicine.

DIAGNOSIS

The clinician who considers the possibility of a bromide intoxication should be able to recognize the condition even without laboratory confirmation in most cases. The history is that of bromide treatment with increasing doses to meet the nervous complications as the early and unrecognized signs of an intoxication appear. The disorientation for time, place, and person, and the lack of insight attract attention to the mental condition soon after lapses of memory begin to occur. The resulting confusion and delirium, dreamy phantasms with hallucinations, often of animals, the macropsia and micropsia, together with confabulation, and lucid intervals of variable length, are suggestive, although not pathognomonic of bromide intoxication. When these symptoms appear in an individual previously normal mentally, and the neurologic signs of corneal or pharyngeal hypoesthesia, ocular disturbances, incoordination, thick speech, and altered reflexes are present, a diagnosis of bromide intoxication is warranted. The blood bromide determination is confirmatory evidence, but the possibility of the bromide intoxication being superimposed on another psychosis should always be kept in mind.

MECHANISM

Not all individuals having a high concentration of bromide in the blood develop symptoms. This suggests the probability that an individual susceptibility exists similar to that for alcohol. Resistance to delirium also varies with age and the general physical condition. Constitutional conditions such as arteriosclerosis, chronic alcoholism, exhaustive and debilitated states, and renal impairments increase the susceptibility. Diet, and especially the amount of salt, influences the retention of the bromide in the body, and therefore the possibility of an intoxication.

The chemical relationship of the bromide and chloride ions in the body is the basis of the intoxication. Normally only minute amounts of bromide are present in the blood. During normal chloride intake, which is 15 grams a day, fairly large doses of bromide can be taken without accumulation in the tissues. An inadequate chloride intake increases the bromide absorption and retention, and if continued, prevents the elimination of the bromide even after further administration of bromide is stopped. Increased chloride intake on the other hand, results in increased bromide replacement by reason of a reversible substitution dependent on mass action. Replacement of more than 40 per cent of the chlorides of the blood by bromides is said to be fatal.

A combined knowledge of the clinical stages and the pharmacology is helpful in the management of the stuporous cases. The blood bromide is usually high. Withdrawal of bromide which has at least controlled the activity in this type of case returns the patient to the irritative stage and again introduces the problem of proper management. There is a temptation to resume the use of bromide, but it only delays the evil day.

Administration of chloride in large amounts during this period may free the bromide from the tissues faster than it can be eliminated. It may accumulate in the blood stream and greatly aggravate the severity of the case. On the other hand, limitation of the chloride slows the rate of bromide elimination and is sometimes helpful in controlling extremely active cases. The complete elimination of the bromide requires from four to eight weeks, but mental symptoms such as confusion and hallucination usually disappear after the first two or three weeks, often when the blood bromide reaches 150-175 mg. per 100 cc.

TREATMENT

Immediate discontinuance of the bromide is the first order of treatment. If the confusion and delirium warrant it, sedatives may be employed. The barbiturates are not always satisfactory.

Paraldehyde and small doses of chloral have usually been our choice. Morphine was used in a postoperative case to obtain the necessary results. Hydrotherapy, sponge baths, tub baths, and blanket packs which help to restrain and limit the activity, are far more valuable than drugs in a hospital.

Elimination of the bromide depends on replacement of the bromide ion by the chloride ion. Controlled daily doses of 1 to 5 grams of sodium chloride, depending on the case, should be used, although some cases do better when the salt in the diet is considered sufficient for the purpose. Fluids should be urged and elimination by the bowels and skin encouraged by the use of enemas and sweats.

The necessity for protecting the patient from injury, as well as from homicidal and suicidal impulses, can be anticipated. Constant nursing care should be provided. Care at home is often impractical, and general hospitals seldom provide the necessary protection for a delirious patient. It is necessary to attend to all of the physical needs of the patient, including rest, food, elimination, and conservation of strength.

The period after disappearance of the mental symptoms warrants caution. The confusional symptoms averaged eighteen days in our cases, but the bromide does not disappear from the blood until after four to eight weeks. This period is often one of mild depression, irritability, emotional instability, and insomnia. Precaution is suggested by our Case V, who committed suicide soon after returning home, although in this case an underlying psychosis had been recognized.

SUMMARY

1. Bromide delirium or intoxication can occur under therapeutic dosage in susceptible individuals.

2. From 3 to 5 per cent of admissions to state hospitals have been found to be due to bromide intoxication.

3. In a private neuropsychiatric hospital the incidence was 4.4 per cent of the total admitted, and 23.4 per cent of the toxic-confusional group.

4. A practical knowledge of the body chemistry for bromide and chloride is helpful in directing treatment.

5. The possibility of a bromide intoxication being superimposed on a preexisting mental disorder should always be considered.

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BROMIDE INTOXICATION

Note: *(All determinations of the blood bromide in our cases were made with the La Motte-Wuth Bromide Comparator, a simple, economical, and satisfactory method for clinical purposes.)

Attorney General Rules on Financing Provisions of Hospital Act

Interpretations of a number of the financing provisions of House Bill 80 and Senate Bill 43, enacted by the 90th General Assembly and providing for reimbursement to hospitals for the care of indigent persons injured in motor vehicle accidents in Ohio are made in an opinion rendered March 19 by Attorney General John W. Bricker in compliance with a request from Glen M. Dailey, registrar of motor vehicles.

Answering Mr. Dailey's questions, Attorney General Bricker held that:

1. The appropriation contained in Amended Senate Bill 43 for reimbursement of hospitals to the extent of 19 cents per motor vehicle registered for the purpose of carrying out the provisions of House Bill 80 is a specific appropriation within the meaning of the term as used in Article 2, Section 22 of the Ohio Constitution and is not merely an amount which may not be exceeded in carrying out the provisions of the act.

2. Such appropriation went into effect on September 28, 1933, and expires March 1, 1935, and any unexpended moneys therein at the end of the calendar years 1933 and 1934 do not lapse.

3. Appropriations for personal service and for supplies and maintenance contained in Senate Bill 43 are not to be deducted from the appropriation for reimbursement for hospitals.

4. Funds may not be transferred from the appropriation for "reimbursement for hospitals" as contained in Senate Bill 43 to the items of personal service or supplies and maintenance contained in such appropriation act, but additional funds may be made available for such personal service or supplies and maintenance items by allowance by the Emergency Board from the contingent appropriation for uses and purposes of such board contained in the general appropriations bill enacted by the 90th General Assembly.

5. The Auditor of State may draw no warrant on the Treasurer of State for the payment of any voucher drawn by the Registrar of Motor Vehicles to reimburse a hospital under the provisions of House Bill 80 until the Director of Finance has certified as to the availability of funds to pay the same in the appropriation against which the warrant is drawn.

6. The term "motor vehicle" as used in House Bill 80 should be defined as set forth in Section 6290, General Code, to wit: "Motor vehicle means any vehicle propelled or drawn by power other than muscular power, except road rollers, traction engines, power shovels and power cranes used in construction work not designed for or employed in general highway transportation, well drilling machinery, ditch digging machinery and farm machinery."

NUMBER OF NEEDY ENTITLED TO MEDICAL CARE PROVIDED BY RELIEF FUNDS INCREASED AS WORK RELIEF PROGRAM IS CURTAILED

Importance of the federal-state plan for furnishing medical care in the home for recipients of unemployment relief as provided in Revised Ohio Supplement No. 1 to Federal Rules and Regulations No. 7 (April, 1934, issue, *The Journal*, pages 242-247) is emphasized by developments of the past month in the emergency relief situation.

Abandonment of the Civil Works Administration program on March 31 and the substitution for it of a modified and curtailed work relief program under the direct supervision and control of the State Emergency Relief Commission, as a part of the plan for direct relief to needy persons, have increased materially the number of persons and families depending upon direct relief, in whole or in part, for necessaries, including medical service.

Under the new relief set-up, the Federal Emergency Relief Administration has allotted to Ohio funds for carrying out a work project program formulated by the Ohio Relief Commission. The work projects program differs from the former Civil Works program in that all persons employed on such projects will be selected on the basis of actual need for relief; employed fewer hours per week at a smaller hourly wage; and will be entitled to direct relief, including medical care, in case their limited earnings are insufficient to meet their necessary budgetary requirements as established by the local Relief Administration.

Because of the limitation in hours of employment, a decrease in the minimum hourly wage, and the limited amount of Federal funds available for work projects, fewer persons will receive the benefit of work relief and more will again be returned to direct relief, including medical service as provided in Rules and Regulations No. 7.

EMPLOYMENT BASED ON ACTUAL NEED

Strict regulations relative to the selection of persons for work projects have been promulgated. Each person employed will work not less than 18 hours per week. Wages will be at the prevailing rate for the occupation and the locality in which the work is done but in no case will be less than will yield 30 cents per hour. The hours of employment will be limited so that the maximum weekly earnings of the employe shall not in any case exceed the amount necessary to meet his budgetary requirement for actual necessities determined by the county case supervisor. However, those unable to earn enough to meet the relief budget certified by the case supervisor will be entitled to direct relief (cash or in kind) for the difference between the certified relief budget and actual earnings.

Because many needy persons in most counties will not be able to earn enough under this program to provide themselves with necessaries and will therefore be required to have direct relief to meet their budgetary deficiency, it is of vital importance that the plan of providing such individuals with medical care established in Ohio in compliance with Federal Rules and Regulations No. 7 be made to function effectively in each county and that physicians rendering service to the needy be compensated in accordance with the increased fee schedule for medical care to the needy put into effect by the State Emergency Relief Commission on April 1, 1934. (April, 1934, issue, *The Journal*, page 242).

ACTIVITY BY COUNTY SOCIETIES ESSENTIAL

It is imperative that the proper officers or committee of each county medical society keep in constant contact with their county relief director; and confer with him in the administrative details of the medical relief plan; advise him of the importance of providing adequate medical care for those in need of it; and insist that necessary funds be made available for compensating physicians under the new and increased fee schedule announced by the State Relief Commission.

As pointed out in the April issue of *The Journal*, action of the State Relief Commission in limiting the amount of money allocated to each county for medical care to the needy to $1.00 per month per family on the relief rolls and providing if the total expenditure for the month exceeds this amount, bills for medical, dental and nursing care shall be paid on a pro-rated basis may have the effect in some counties of nullifying the increased medical fees authorized by the Commission.

Should this arrangement result in inequities and fail to provide sufficient funds for necessary medical attention in accordance with the increased fee schedule, concerted effort by the medical profession may be necessary to secure modification of the pro-rata medical set-up by the State Relief Commission.

RESULTS OF PLAN SHOULD BE CHECKED

Physicians in each county should keep themselves adequately informed on all details of the medical relief plan and how it is functioning in order that a check may be had on whether or not it is insuring adequate medical care for families on relief and payment to physicians for rendering such service.

Every physician rendering service to the needy should secure from the relief director of his

county a copy of Revised Ohio Supplement No. 1, effective April 1 and issued March 24 by the State Relief Commission, containing the regulations and rules of procedure governing medical care to recipients of relief, the increased schedule of medical fees, and data concerning the payment of bills for medical service, medicine, etc., to guide him in making out reports and fee bills. Compliance with the regulations and prompt submission of fee bills by physicians will help to minimize confusion and delay and speed up payment of physicians' bills.

Local Medical Advisory Committee in Each County Considered

The State Relief Commission at present has under consideration a plan for having established in each county a local medical advisory committee, as contemplated in Federal Rules and Regulations No. 7, to advise and cooperate with the county relief director in administrative details in connection with all medical and public health aspects of the county's poor relief program.

It is understood that the contemplated plan of the State Relief Commission provides for the establishment in each county of a committee of not more than three physicians, one of whom shall be the local health commissioner and two to be appointed by the county medical society, to act in an advisory capacity to the county relief director. This committee would consult with the director in cases requiring professional judgment or advice; approve all proposed public health projects in the county before their inception so as to avoid duplication or conflict with the health agencies already in existence; advise and consult with the county relief director concerning injured employes of the Work Division of the Emergency Relief Administration, and assume responsibility for the authorization of medicine, medical supplies and medical attendance.

AUTHORIZATION OFFICER PROVIDED FOR

An authorization officer, probably the local county health commissioner when available, would be appointed. If the county health commissioner is unable to serve in this capacity, the contemplated plan provides for the appointment of any physician, such as the city health officer or private physician who is acceptable to the medical advisory committee and willing to fill the office, as authorization officer.

Wherever possible the clerk to the authorization officer would be given office space in the county department of health where records and information of the health department are available and the clerk would make all authorizations for medicine, medical supplies and medical attendance under the direction and advice of the local authorization officer.

The local authorization officer and local health department would have access to the social data compiled by the local Emergency Relief Administration and through the medical advisory committee would have authority in all cases applying for, or receiving relief medical care, to direct the county case workers in respect to such medical care.

The health commissioner (or authorization officer) and other members of the medical advisory committee would be expected to acquaint themselves with the current rules and regulations of the state and federal emergency relief administrations, and abide by them in directing and advising authorization for medical care in the home.

OTHER DETAILS OF PROPOSED PLAN

In addition, the proposed plan provides:

Where possible families on the case load be furnished with a list of physicians whose services are available in that locality.

Physicians agreeing to participate in this program be furnished from time to time with a list of the families on the case load.

In cases where the services of a physician are required, families on relief may call their family physician providing he has signified his willingness to serve families on relief, and the attending physician should send a notification of the case to the medical authorization officer as soon as possible or within 48 hours after the first call and before the second visit.

Forms RM and RO would be used in authorizing medical care in the home and the itemized statements of the physician, dentist or nurse would be sent to the local Emergency Relief Director for payment.

The local relief director would be expected to furnish all printed matter, postage and clerical service necessary in carrying out the foregoing plan.

Medical Care Provided for Those Disabled at Work

A new plan providing for medical, surgical and hospital care of those sustaining injuries in the course of or arising out of employment on Work Division projects, *but eliminating the payment of monetary compensation for disability or lost time,* has been established by the State Relief Commission.

The plan differs in several respects from the medical treatment plan set up by the Federal Civil Works Administration to handle injuries sustained by workmen on Civil Works projects and administered during the life of the Civil Works program by the Federal Employes' Compensation Commission.

Those injured on projects under the Works Division of the State Relief Commission will be

provided with medical and hospital care at the expense of the State Relief Commission.

HOW MEDICAL FEES ARE DETERMINED

Fees for medical service are not to be in excess of those ordinarily charged persons in the same income class as the injured workmen.

It is anticipated that for ordinary minor injuries the fee schedule for office and house calls will, for the time being at least, be the fees contained in the medical fee schedule put into effect by the Commission on April 1 (April, 1934, issue, *The Journal*, page 242) and applying to medical service rendered to all those on relief through federal-state funds. In major injuries sustained by those while employed on work relief projects as a part of direct relief, the current medical fee schedule of the State Industrial Commission is expected to apply.

In lieu of compensation, incapacitated workmen will receive direct relief (cash or kind to supply budgetary necessities only) under the emergency relief program during the period of incapacitation.

Administration of the medical treatment plan for injured Work Division employes will be handled by the Department of Safety of the State Relief Commission to which all reports, data and bills will be transmitted by the county relief directors for review and payment.

PROCEDURE OUTLINED IN INSTRUCTIONS

The plan and procedure, transmitted to all county relief directors under date of April 9 by the Commission, follows:

1. Each county relief director shall prepare, in conjunction with his local medical society, a list of physicians, hospitals and ambulances who desire to accept for treatment employes injured upon work projects under the Federal Emergency Relief Administration. This list should include physicians in the locality who are licensed to practice medicine in Ohio and who, by training and experience, are qualified to render such service. Fees for medical service shall not be in excess of those ordinarily charged persons in the same income class as the injured workmen, and in no event shall they exceed those allowed under the current General and Special Fee Schedule of the Industrial Commission of Ohio.

2. Advise each project superintendent of the name, address and phone number of the listed: (a) doctor, (b) ambulance, (c) hospital, located nearest the project which he is supervising. This information shall be entered in the spaces provided on First Aid Instructions No. 1 (Form 1803) which should be kept with the first aid kit on the project and available at all times.

PROMPT CARE BY PHYSICIAN ORDERED

3. Every injury, except eye injuries, no matter how slight, shall receive first aid treatment on the job in accordance with First Aid Instructions No. 1 and American Red Cross First Aid Text Book. *All* eye injuries and puncture wounds shall be sent to the doctor, as well as all other injuries needing such care.

4. Every injury shall be reported on (Form IR-1) which shall be filled out completely on the job at the time of the injury and signed by:

a. The injured workman (if possible).
b. Two witnesses (if possible).
c. The injured workman's foreman.

This form and a duplicate copy shall be turned into the county director's office on the day of injury.

5. Emergency cases shall be sent by the foreman to the nearest available listed physician or hospital. If no emergency exists the injured workman may select any listed physician within reasonable proximity of the workman's residence.

REPORTS TO BE MADE IN DUPLICATE

6. A medical report of the injury shall be made in duplicate on (Form FB-1), which shall be issued to the attending physician by the county relief director after filling out the request for treatment at the top of the form.

7. Upon completion of Form FB-1 in duplicate by the attending physician and signed by him, it should be forwarded to the local relief director's office, attached to the corresponding Form IR-1, also made out in duplicate, and forwarded to the Department of Safety, Wyandotte Building, Columbus, Ohio.

8. All fatal and serious accidents shall be thoroughly investigated immediately and signed statements shall be obtained from all witnesses thereto.

9. A telegraphic report of all fatal and serious accidents shall be made to the Safety Department, Wyandotte Building, Columbus, immediately.

10. A complete card file of injuries involving loss of time shall be maintained in the county office showing the weekly physical status of each incapacitated man. As soon as the injured workman is released from medical treatment he shall be given employment consistent with his physical condition as recommended by the attending physician. The county case supervisor shall be responsible for seeing that the injured workman and his dependents are properly cared for, and that the injured workman is returned to work as soon as practicable. Medical re-examination to determine the physical status of an injured workman may be authorized by the county relief director.

COSTS PAID BY STATE RELIEF COMMISSION

11. All proper medical costs incident to injuries received by employes of the State Emergency Relief Commission in the course of their employment on work projects under F.E.R.A. will be paid by the State Relief Commission of Ohio,

but no monetary compensation will be paid to persons incapacitated on account of such injuries. Such persons shall receive direct relief during such period of incapacitation.

Additional and supplemental instructions relative to jurisdiction, procedure, medical and hospital fees, etc., in connection with the medical plan for injured Work Division employes, were issued by the State Relief Commission under date of April 14 to clarify several provisions of the original instructions issued under date of April 9. These instructions are in part as follows:

Jurisdiction—The State Relief Commission of Ohio will pay, from the Columbus office, the proper medical and hospital fees for such injuries sustained by employes on projects under Work Division of the Federal Emergency Relief Administration as are received in the course of their employment on these projects and arise out of such employment. This responsibility extends only to Work projects under the Federal Emergency Relief Administration. (Form F.E.R.A.-141).

The responsibility for medical treatment for injuries received on work relief projects (Form C.R.-1), upon which relief is paid in cash or in kind, rests with the local authorities as described in Rules and Regulations No. 3, page 311, F.E.R.A. Manual.

HOW REPORTS SHOULD BE HANDLED

Procedure—The county relief director shall issue a request for treatment (Form F.B.-1) in duplicate for each injured workman requiring medical or hospital care. The physician and/or the hospital shall complete the medical report and fee bill and return both signed copies to the county director, who will attach them to their corresponding injury reports (Form IR-1). After certifying at the bottom of the injury report that the injured man was an employe of the local relief administration and that the medical services were rendered as indicated on the attached fee bill, the county director will forward them to the Safety Department of the State Relief Commission at Columbus for payment.

Fees—The following instructions are contained in Injury Procedure and Form FB-1: "Fees shall be consistent with those ordinarily charged persons in the same income class as the injured workman, and in no event shall they exceed those allowed under the current General and Special Fee Schedule of the Industrial Commission of Ohio".

This is construed as adopting the fee schedule for "Medical Care Provided in the Home to Recipients of Unemployment Relief" as found in Supplement No. 1 (Revised) to Rules and Regulations No. 7 of the Federal Emergency Relief Administration. (*Note*: See April issue, *The Journal*, page 242).

It will be noted the plan provides for cooperation between the county medical society and the county relief director in compiling a list of physicians willing to accept injured work division employes for treatment and preserves for the injured workman the right to select any physician from the list of physicians who have notified the county relief director of their willingness to handle such cases.

Each county medical society should confer at once with the relief director of the county on this new set-up and assist him in preparing the required list of physicians. Each relief director should be advised of the importance of prompt medical attention by a licensed physician for all injured workmen. He should be requested to instruct project foremen not to delay in getting injured workmen into the hands of a physician, not to place too much reliance on first aid treatment on the job, and not to minimize the danger of serious infection and complications following all injuries.

OSMJ

Prize of $1,500 Offered For Best Essay on Surgical Subject

Announcement has been made by the Philadelphia Academy of Surgery of an essay contest, the winner of which will be awarded $1,500 to be known as the Samuel D. Gross Prize in memory of Dr. Samuel D. Gross, at one time professor of surgery at Jefferson Medical College; one of the great surgeons and authors of the early years of the 19th Century; at one time a leading figure in the early medical history of Ohio in association with Dr. Daniel Drake; and a pioneer in medical organization in Ohio.

The prize is to be awarded every five years to the writer of the best original essay, not exceeding 150 printed pages in length, illustrative of some subject in surgical pathology or surgical practice founded upon original investigations. Each candidate must be an American citizen. Essays should be sent to the Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 South 22nd Street, Philadelphia, on or before January 1, 1935.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

CHANGES IN WORKMEN'S COMPENSATION LAW AND ADMINISTRATION—RECOMMENDATIONS OF OHIO STATE MEDICAL ASSOCIATION

Specific and constructive recommendations for improving the administrative procedure under the Ohio Workmen's Compensation Law and for eliminating abuses in the workmen's compensation system have been presented by the Special Committee on Workmen's Compensation of the Ohio State Medical Association to the Governor's Investigating Committee on Workmen's Compensation, appointed recently by Governor White and which has launched an investigation of the operation and administration of the Workmen's Compensation Law and set-up. (March, 1934, issue of *The Journal*, pages 171-173).

The Governor's Committee, consisting of S. P. Bush, Columbus, chairman; O. B. Chapman, Dayton, acting president of the Ohio State Federation of Labor; Thomas J. Donnelly, Columbus, secretary of the Ohio State Federation of Labor; Charles F. Michael, Bucyrus, president of the Ohio Manufacturers' Association, and Warren F. Perry, Columbus, secretary of the Ohio Manufacturers' Association, shortly after it had begun its study of the workmen's compensation question, requested the Ohio State Medical Association to submit for its consideration recommendations, suggestions and criticisms which might be helpful to the Governor's committee in its investigation.

The request of the Governor's committee was immediately taken under consideration by the Special Committee on Workmen's Compensation of the State Medical Association, consisting of Dr. B. J. Hein, Toledo, chairman, Dr. J. Craig Bowman, Upper Sandusky, and Dr. L. L. Bigelow, Columbus.

A statement and recommendations were formulated by the State Association committee, based on studies of workmen's compensation problems made by that committee and others of the State Association over a period of time.

A conference was held with the Governor's committee April 9 in Columbus and was attended by Dr. C. L. Cummer, Cleveland, president, Dr. Bigelow, and Executive Secretary Martin, representing the State Medical Association, and members of the Governor's committee.

Following a prolonged informal discussion of workmen's compensation problems, especially those involving medical, hospital and nursing services, the following statement and recommendations, drafted by the State Medical Association's committee, were submitted to the Governor's committee for its consideration and study:

O. S. M. A. COMMITTEE'S REPORT

Workmen's compensation has been established in Ohio as a social, humanitarian, economic and governmental principle. The medical profession in common with other groups sincerely concerned with this principle, desires to cooperate in efficient, honest administration.

The importance of the medical profession in the structure of workmen's compensation cannot be over-emphasized. Prompt recovery from industrial injuries, periods of disability, including compensation to injured workmen, problems of prospective periods of disability, degree of disability, and eventually even the amount of premiums and the status of the fund itself, depend on competent, qualified, honest medical service.

Those disabled in the course of employment are entitled to the highest grade of medical care. Speaking for the organized medical profession, we realize the acute and serious problems confronting the Industrial Commission and the workmen's compensation fund, at the present time, and we wish to support and cooperate to the fullest with your committee and with other groups sincerely concerned with problems and principles of workmen's compensation.

We realize that there have been abuses by some physicians and some hospitals. We do not condone, indeed we condemn, those persons who have unfairly and dishonestly sought to take advantage of the workmen's compensation fund; and we desire to assist you in eliminating such abuses.

Undoubtedly, there has been a number of cases which were unreasonably prolonged or overtreated, which have added to the costs of administration—not only in medical and hospital fees, but in compensation to the claimants. We believe that a correction of these abuses will go far toward solving the problems now confronting the Commission, and that such a solution is practical.

It is recognized, and perhaps no detailed proof is required at this time to establish the fact, that the Medical Department of the Commission at present is woefully undermanned in common with some other departments of the Commission. Concerted effort can be made to secure more adequate appropriations to increase the personnel, particularly if the administrative divisions dealing with workmen's compensation are placed under the direct control of the Commission itself and employes, especially those with a professional status, are removed from civil service.

REGIONAL BOARDS OF REVIEW SUGGESTED

We respectfully submit for your consideration the following specific recommendations:

A. That local regional medical boards of review be selected to review and pass upon chronic, prolonged, unusual or revived cases. It is our belief that such medical boards of review would save many times their cost by eliminating malingering, fraudulent or exorbitant medical and hospital costs. (It is not intended in this recommendation to suggest that such boards take over the *treatment* of cases, but to examine and determine the record, as well as to examine and record findings on the physical condition of claimants).

B. That routine audit of bills submitted by physicians and hospitals be placed in charge of

an auditor assigned to the Medical Department and that the physician staff members of the Department be confined in their duties to medical interpretation of the reports submitted. This recommendation, of course, means that neither the auditor nor the Claims Department should assume to reduce or adjust medical bills where the medical record requires interpretation, such as unusual cases, by the Medical Department.

C. That the Commission and its Medical Department adhere more strictly to the Rules and Regulations which became effective on September 15, 1932; especially in regard to the requirements for reports by physicians and hospitals. And that in those types of treatment for which permission must be granted in advance, such permission be granted or refused promptly.

BETTER CHECK ON UNUSUAL CASES NECESSARY

D. That the Medical Department formulate (with the assistance of this committee if desired) a tabulation of the average length of treatment, number of dressings, period of hospitalization, convalescence, length of disability, and other major factors in frequently encountered types of injuries and disabilities, to aid them in determining usual medical costs and compensation.

E. That a study be made of the problem of aggravation of pre-existing conditions such as arthritis, syphilis, etc.

F. That provision be made not only for efficient supervision and coordination of the various departments of the Commission, particularly Claims, Medical and Legal Departments, but that a centralized authoritative department be set up to promote speed, efficiency and prompt replies to inquiries, in order to eliminate present prolonged delays in the payment of medical bills even following authorization, and to avoid delay or neglect in answering correspondence from physicians and others concerning pending cases.

PROSECUTION OF VIOLATORS

G. That in flagrant cases of abuse or fraud, prosecutions be undertaken promptly as provided under Sections 1465-109 and 1465-110. That if local prosecuting attorneys and other enforcement officials appear reluctant to prosecute as requested on being furnished information and files, that the Industrial Commission and the Department of Industrial Relations ask the Attorney General to designate a staff member to assist and support the prosecuting attorney in such cases; or that a division of enforcement be created under the direction of the Commission.

H. That more authority be vested in the local regional offices of the Commission in those large industrial centers where such offices are maintained, to the end that in all prolonged, chronic or revived cases definite and frequent check-ups be made of physicians' and hospitals' services. That in such cases the employer be informed of any unusual factors in the case, whether suspected over-treatment, excessive hospitalization, undue prolongation of the period of disability, or malingering, so that he may assist toward prompt rehabilitation.

I. That in cases of emergency or serious injury requiring prompt treatment, unusual care, or added facilities, including special nursing service, authority be granted by the local regional office of the Commission.

J. That concerted effort be made by those earnestly interested in safeguarding the principle of workmen's compensation and the workmen's compensation fund, to secure from the Legislature adequate appropriations for administration, as sufficient qualified personnel to handle the recommendations herein contained would safeguard and preserve the workmen's compensation fund, reduce the relative amount now being paid in compensation, medical and hospital fees, and save in undue compensation and payment for services an amount many times the added expense.

K. We pledge medical organization to thorough cooperation on the suggestions made herein, as well as our earnest effort in eliminating all abuses chargeable to members of the medical profession.

STATUTORY CHANGES RECOMMENDED

Revision of the Workmen's Compensation Law in accordance with recommendations made by the Governor's special investigating committee was under way at the time this was written.

A preliminary and partial report to Governor White incorporated numerous findings of the committee after a month's study of the question and several recommendations for immediate amendment of the Workmen's Compensation Law. These recommendations were transmitted to the Ohio General Assembly by Governor White in a special message and measures amending the law in accordance with suggestions of the committee were introduced in the General Assembly.

The committee's recommendations which were the basis for legislation were:

1. That the Workmen's Compensation Law be amended to permit the transfer of the personnel of the Division of Workmen's Compensation, Department of Industrial Relations, from the jurisdiction of the Director of Industrial Relations to the State Industrial Commission and granting the State Industrial Commission the power it had previous to 1921, to select or make changes and direct the activities of all employes of the Division of Workmen's Compensation. Such statutory change, the committee pointed out, will give the State Industrial Commission complete responsibility of administration and the necessary powers for thorough and business-like administration of the compensation law.

2. That the medical and legal staffs and the heads of departments of the Division of Workmen's Compensation be removed from civil service and that provision be made that the State Industrial Commission appoint such employes, appointments to be made on the basis of training and experience.

3. That an emergency appropriation of $250,000 be made to be used by the State Industrial Commission for employing additional personnel for undermanned departments of the Division of Workmen's Compensation. (This recommendation is partially provided for in pending legislation appropriating $125,000).

A fourth specific recommendation was made by the investigating committee in its preliminary re-

port but the committee suggested that no legislative action be taken on it at present. This was that a permanent advisory committee on workmen's compensation be provided for by statute. This body would serve without pay other than traveling expenses and would assist the State Industrial Commission in an advisory capacity in administration of the compensation law.

According to the investigating committee's partial report to the Governor, during the short time the committee has been organized and functioning it has discovered a number of factors which the committee believe are partially responsible for administrative weakness, delays and abuses in the operation of the compensation law. Included among these findings of the committee were:

DEPARTMENT INADEQUATELY MANNED

The medical staff at Division of Workmen's Compensation is inadequate for the expeditious handling of the work under any system and the present system of medical examination is in need of revision to the end that just and prompt settlement of claims may be had.

The department is swamped with claims for re-hearing and modification of awards, partially due to the activities of some attorneys in influencing former claimants to seek additional compensation and to carry their claims into court, thus creating considerable additional work and expense for the department.

Records of the department are too readily available to persons without sufficient evidence that examination of files is proper or necessary.

The number of field workers engaged in investigating claims is inadequate, causing delays in making awards.

The number of payroll auditors is inadequate and in some cases their competency has been wholly lacking and in others open to question, resulting in heavy losses to the fund.

The auditing department is not functioning effectively and should be reorganized in such a way that all employers, required by statute to do so, shall be compelled to participate in workmen's compensation.

Some courts and some county prosecuting officers are not cooperating with the department in enforcing compliance with the compensation law, seriously hampering the work of the field force in this respect.

The actuarial department has not been able to function effectively because of inadequate personnel.

The number of referees whose function is to investigate and prepare cases for decisions is inadequate.

Many delays are due to lack of adequate legal personnel.

The Industrial Commission itself is overburdened with administrative detail that should be delegated to others, thus preventing the Commission from hearing and passing judgment on claims as promptly as is desirable.

A number of hearings have been held by the investigating committee for the purpose of obtaining recommendations and criticism from any persons interested in workmen's compensation and more will be held before the committee concludes its investigation.

At a later date the committee will file a second report dealing with details of organization and administration for the advice of the Industrial Commission itself but which will not necessarily require legislative action.

OSMJ

Student Health Physicians Meet

Dr. Lee H. Ferguson, Western Reserve University, was elected president of the Ohio Student Health Association at its 10th annual meeting, April 6 at the Deshler-Wallick Hotel, Columbus. Dr. John M. McCleery, Muskingum College, was elected vice president and Dr. R. W. Bradshaw, Oberlin College, was re-elected secretary-treasurer.

Dr. Robert N. Hoyt, Western Reserve University, Dr. L. B. Chenoweth, University of Cincinnati, and Dr. A B. Denison, Western Reserve University, addressed the morning session of the meeting. Dr. Hoyt and Dr. Chenoweth spoke on "The Content and Teaching of College Courses in Hygiene" and Dr. Denison on "Mental Hygiene Services for College Students".

Subjects presented at the afternoon session were: "Diagnosis, Prevention and Treatment of Tuberculosis Among College Students", by Dr. Ferguson and Dr. F. C. Anderson, superintendent of the Ohio State Sanitarium, and "Medical Aspects of the Heart of College Students", by Dr. J. W. Wilce, Ohio State University.

At a luncheon meeting, a roundtable discussion on the following problems was conducted: Treatment of the common cold; value of personality estimates; should the college assume any part of the expense in the correction of physical defects of the students?; ways and means of obtaining special treatment for students with defects; problem of the underweight student who will not take sufficient food and rest.

OSMJ

Graduates of the School of Medicine, University of Toronto, residing in Cleveland, are planning a reunion of all alumni attending the meetings of the American Medical Association in that city, June 11-15. A dinner will be held at the Carter Hotel on Wednesday evening, June 13, at 6:30 o'clock. A committee consisting of Drs. W. J. Abbott, Howard Dittrick and W. S. Duncan is in charge of arrangements.

Cleveland Committees Working Hard to Make A.M.A. Meeting There, June 11-15, Best Ever Held in National Organization

Under the direction of Dr. C. W. Stone, general chairman on arrangements, local arrangements and details in connection with the 1934 Session of the American Medical Association to be held in Cleveland, June 11-15 are rapidly being completed.

Hotel reservations for the Cleveland meeting are beginning to pour into various Cleveland hotels, so those contemplating attending the session should forward their reservations promptly to Dr. H. C. King, 1604 Terminal Tower, Cleveland, chairman of the sub-committee on hotels. A list of Cleveland hotels, their rates and accommodations was published in the February 24, 1934, issue of *The Journal of the American Medical Association*, on page 38 of the Advertising Section.

One of the finest scientific programs ever presented at an A.M.A. meeting has been arranged and the Scientific Exhibit promises to be bigger and better than ever. The scientific meetings and exhibits will be at the Cleveland Public Auditorium.

The first general meeting will be held on Tuesday evening, June 12, at the Music Hall of the Cleveland Public Auditorium, presided over by Dr. Dean Lewis, president of the American Medical Association. The program of this session will consist of an address of welcome by Mayor Harry L. Davis of Cleveland; addresses by Dr. A. A. Jenkins, president of the Cleveland Academy of Medicine and Dr. C. L. Cummer, president of the Ohio State Medical Association; address by U. S. Senator Robert J. Bulkley, Cleveland; installation of the incoming president, Dr. Walter L. Bierring; address by Dr. Bierring, and presentation of medal to Dr. Lewis, retiring president.

The President's Reception will be held on Thursday evening, June 14 at the Hotel Cleveland.

Following are the chairmen of the various local committees which are assisting Dr. Stone and cooperating with the staff of the A.M.A. in planning for the Cleveland meeting:

Subcommittee on Sections and Section Work—H. V. Paryzek.

a. Practice of Medicine—M. A. Blankenhorn.
b. Surgery—General and Abdominal—C. H. Lenhart.
c. Obstetrics, Gynecology and Abdominal Surgery—A. J. Skeel.
d. Ophthalmology—P. V. Moore.
e. Laryngology, Otology and Rhinology—W. V. Mullin.
f. Diseases of Children—C. W. Burhans.
g. Urology—T. P. Shupe.
h. Orthopedic Surgery—W. G. Stern.
i. Gastroenterology and Proctology—F. C. Oldenburg and C. C. Perry.
j. Radiology—W. C. Hill and L. A. Pomeroy.
k. Pharmacology and Therapeutics—Torald Sollmann.
l. Pathology and Physiology—H. T. Karsner and C. J. Wiggers.
m. Nervous and Mental Diseases—H. H. Drysdale.
n. Dermatology and Syphilology—J. R. Driver.
o. Preventive and Industrial Medicine and Public Health—A. G. Cranch and H. L. Rockwood.

Subcommittee on Registration—Richard Dexter.

Subcommittee on Printing and Information—D. M. Glover.

Subcommittee on Transportation—P. V. Duffy.

Subcommittee on Technical Exhibits—M. B. Cohen.

Subcommittee on Scientific Exhibits—R. L. Haden.

Subcommittee on Hotels—H. C. King.

Subcommittee on Publicity—Mr. H. Van Y. Caldwell.

Subcommittee on Finance—A. A. Jenkins.

Subcommittee on Women Physicians—Anna May Young.

Subcommittee on Entertainment.

a. Dinner to Delegates—C. L. Cummer and C. W. Stone.
b. Alumni Dinners—H. D. Piercy.
c. Opening General Meeting—H. G. Sloan.
d. President's Reception and Ball—H. L. Sanford.
e. Golf—J. B. Morgan.
f. Women Guests and Women's Auxiliary—Mrs. C. L. Cummer.

A program of entertainment for women guests is being arranged in addition to the regular program to be presented at the meeting of the National Women's Auxiliary.

OSMJ

American Medical Golfers to Play In Cleveland on June 11

The American Medical Golfing Association will hold its twentieth annual tournament at the Mayfield Country Club in Cleveland on Monday, June 11, 1934.

Thirty-six holes of golf will be played in competition for the fifty trophies and prizes in the eight events. The trophies include the Association Championship for thirty-six holes gross, the Association Handicap Championship for thirty-six holes net, the Choice Score Handicap Championship for thirty-six holes gross, the low gross Eighteen Hole Championship, the low net Eigh-

teen Hole Handicap Championship, the Maturity Event limited to Fellows over 60 years of age, the Oldguard Championship limited to competition of past presidents, and the Kickers Handicap. Other events and prizes will be announced at the first tee.

Dr. Homer K. Nicoll of Chicago is president and Dr. Charles Lukens of Toledo and Dr. John W. Powers of Milwaukee are vice-presidents of the Golfing Association.

The Cleveland Committee on Arrangements is under the chairmanship of Dr. John B. Morgan, 1301 Medical Arts Building, Cleveland. He will be assisted by Drs. R. H. Birge, A. V. Boysen, E. F. Freedman, F. T. Gallagher, Secord Large, E. P. McNamee, J. J. Marek, Theodore Miller, U. V. Portman and M. A. Thomas.

The Mayfield Country Club of Cleveland is described by Chairman Morgan as "probably the finest course in the district, and certainly one of the most interesting. Many championships have been held on this course, and I am sure the visiting doctors will be delighted with it in every sense of the word. It has a most beautiful club house, and we can promise a merry nineteenth hole and a dinner fit for a champion."

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A.M.G.A. Write the Executive Secretary, Bill Burns, 4421 Woodward Avenue, Detroit, for an application blank. Participants in the A.M.G.A. tournament are required to furnish their home club handicap, signed by the secretary. No handicap over 25 is allowed, except in the Kickers'. No trophy is awarded a Fellow who is absent from the annual dinner.

OSMJ

Venereal Disease Information

For a number of years the U. S. Public Health Service has been publishing, for the information of physicians, health officers, and others, a monthly abstract journal known as "Venereal Disease Information." This publication contains usually one original article on a subject of general interest in connection with the venereal diseases and numerous abstracts from the current literature pertaining to these diseases. In the preparation of this abstract journal more than 350 of the leading medical journals of the world are reviewed and abstracts made of the articles on this subject.

The cost of "Venereal Disease Information" is fifty cents per annum, payable in advance to the Superintendent of Documents, Government Printing Office, Washington, D. C. This charge represents only a small portion of the total expense of preparation, the journal being a contribution of the Public Health Service in its program with State and local health departments directed against the venereal diseases.

Hospital Problems Are Discussed at Tri-State Meeting in Cincinnati

Joint meeting of the Ohio, Kentucky and West Virginia State Hospital Associations, Ohio Dietetic Association, Ohio Association of Record Librarians and Ohio Association of Nurse Anesthetists was held at the Netherland Plaza Hotel, Cincinnati, April 17, 18 and 19.

One of the principal subjects discussed by the representatives of the hospital groups was that relating to proposed government aid for hospitals for the care of the indigent. Among those speaking on the question were N. W. Faxon, president of the American Hospital Association; Fred K. Hoehler, director of public safety, Cincinnati; Guy J. Clark, secretary of the Cleveland Hospital Council, and Rev. M. F. Griffin, Cleveland, a trustee of the American Hospital Association.

S. A. Postle, division chief, Federal Food and Drug Administration, discussed legislation pertaining to food, drugs and cosmetics now pending in Congress and the activities of his department.

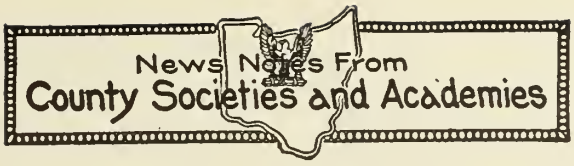
Dr. Irvin Abell, professor of surgery, University of Louisville, and C. C. Little, managing director of the American Society for the Control of Cancer, were speakers at a public meeting on "Cancer" sponsored by the various organizations.

Numerous problems relating to hospital administration, professional relations, finances, etc., were discussed at business sessions held by each of the organizations.

At the closing session of the Ohio Hospital Association meeting, J. R. Mannix, University Hospitals, Cleveland, was installed as president and the following officers elected: President-elect, Rev. Lewis Carroll, Christ Hospital, Cincinnati; vice presidents, Margaret Reilly, University Hospital, Columbus, and Sister M. Raymond, Good Samaritan Hospital, Zanesville; treasurer, Rev. M. F. Griffin, Cleveland; trustees, Dr. E. R. Crew, Miami Valley Hospital, Dayton; Rev. Frank G. Fowler, White Cross Hosiptal, Columbus, Dr. C. S. Woods, St. Luke's Hospital, Cleveland, Mary Yeager, Women's and Children's Hospital, Toledo, and executive secretary, A. E. Hardgrove, Akron City Hospital.

OSMJ

Ohio physicians who may be considering placing their delinquent accounts in the hands of a collection agency will be interested in an article published in the March 31, 1934, issue of *The Journal of the American Medical Association* regarding the Birdsell Loan and Finance Company, Evanston, Illinois, which is making a bid for business among physicians of the Middle-west. According to that article, the Chicago Better Business Bureau has received numerous complaints concerning the activities and methods of this company.



First District

ACADEMY OF MEDICINE OF CINCINNATI
(Harold F. Downing, M.D., Secretary)

April 2—General Session. Program: "Remarks on the General Hospital", C. A. Dykstra, city manager of Cincinnati; "The Prostate—After Three Years Resection", Dr. Charles J. McDevitt; discussion by Dr. Gordon F. McKim.

April 9—Joint meeting with the Cincinnati Dental Society. Program: "Diseases of the Mouth and Jaws", Dr. Gordon B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School of Medicine.

April 16—General Session. Program: "Bacteriological Study of Acute Enteritis in Infants and Young Children", Dr. Merlin L. Cooper; discussion by Dr. Stanley E. Dorst and Dr. Lee Foshay; "The Diagnosis of Certain Blood Dyscrasias and Their Treatment by Splenectomy", Dr. Joseph N. Ganim and Dr. Ralph W. Good.

April 23—General Session. Program: "The Differential Diagnosis of Gastric Ulcer, Duodenal Ulcer and Cancer of the Stomach", Dr. Clyde S. Roof; discussion by Dr. J. Louis Ransohoff and Dr. Leon Schiff; "Angina Pectoris", Dr. Clifford J. Straehley; discussion by Dr. J. E. Benjamin.

April 30—General Session. Program: "Optic Neuritis Due to Lead Intoxication", Dr. Louis G. Heyn and Dr. Donald J. Lyle; discussion by Dr. Robert A. Kehoe and Dr. Clarence King; "Peptic Ulcer of Meckel's Diverticulum", Dr. Lloyd B. Johnston; discussion by Dr. George Renner, Jr.

Clermont County Medical Society met in regular session April 18 at Owensville with Dr. Charles T. Souther and Dr. C. W. Koehler, both of Cincinnati, as guest speakers. Dr. Souther discussed "Anastomosis of the Large Bowel", and Dr. Koehler spoke on "Indications for *X*-ray Therapy". A paper on "A Simple Operation for Ingrowing Nail, Completely on Soft Parts" was presented by Dr. K. B. Hanson.—Bulletin.

Fayette County Medical Society met March 8 at Washington C. H. The guest speaker was Dr. Parke G. Smith, Cincinnati, councilor of the First District, who discussed "The Movable Kidney". A motion picture dealing with the subject was presented.—News Clipping.

Warren County Medical Society was addressed by Dr. J. L. Ransohoff, Cincinnati, at its meeting April 3 at Lebanon.—News Clipping.

Second District

Champaign County Medical Society in session April 4 at Urbana discussed the question of medical care for the indigent. A roundtable discussion on the rules and regulations, fee schedule, etc., of the State Relief Commission was held in charge of Dr. D. C. Houser.—Bulletin.

Darke County Medical Society was addressed on March 16 by Dr. R. D. Arn, Springfield, on "Head Injuries". Dinner was served preceding the program. On April 20 the society held a dinner meeting at the Christian Church, Greenville, and was addressed by Dr. B. A. Schwartz, Cincinnati, on "Heart Disease in General Practice".—Bulletin.

Miami County Medical Society in session April 6 at the Studer Hospital, Troy, voted to establish a credit rating bureau as recommended by a special committee consisting of Drs. F. D. Kiser, G. E. McCullough and E. A. Yates. During the business session, a general discussion was held relative to medical care for the indigent. The scientific program was presented by Dr. Robert D. Spencer, Dr. J. R. Caywood and Dr. Don Deeter. They gave a symposium on "Chronic Abdominal Pathology".—News Clipping.

Montgomery County Medical Society met in special session April 3 to discuss medical care to the indigent and the medical program of the State Relief Commission. Mark Eshbaugh, county relief director, was present and opened the discussion.

On April 6 the society held a dinner meeting at the Van Cleve Hotel. The guest speaker was Dr. J. W. Carmack, professor of otology, rhinology and laryngology, University of Indiana, who discussed "The Cooperation of the General Physician and the Otolaryngologist in the Treatment of Nasal Sinus Infections".

The society held a dinner meeting on April 20 at the National Military Home. The program was presented by members of the home's medical staff. —Bulletin.

Preble County Medical Society was addressed on March 15 by Dr. Johnson McGuire, Cincinnati, on "Cardiac Irregularities".

On April 19, the society had as its guest speaker, Dr. Leon Schiff, Cincinnati, who spoke on "Gall Bladder Disease".—Bulletin.

Third District

Allen County—The Academy of Medicine of Lima and Allen County was addressed on March

20 by Dr. Karl Figley, Toledo, on "Asthma".—News Clipping.

Auglaize County Medical Society held its regular session on April 12 at the Idlewild Club at Lake St. Marys. A fish dinner was given by Dr. Harry S. Noble, St. Marys. The dinner and meeting were attended by 20 members and 25 visiting physicians from adjacent counties. The guest speaker was Dr. Robert C. Austin, Dayton, who discussed "Intestinal Obstruction" especially from the standpoints of the best anesthetic, the urgency of correct diagnosis and the necessity for complete treatment. Dr. Paul C. Bratten, New Bremen, and Dr. Robert E. Boswell, St. Mary's were admitted to membership.—C. C. Berlin, M.D., secretary.

Hancock County Medical Society met in regular session April 5 at the Elks' Club, Findlay. Dr. R. E. McBroom, McComb, was admitted to membership. Dr. A. S. Avery, Toledo, addressed the society on "Trans-Urethral Prostatectomy". The paper was very interesting and well received.—H. O. Crosby, M.D., secretary.

Hardin County Medical Society met on March 27 at Ohio Northern University, Ada, with pharmacists of the county as its guests. Following a dinner, a four-reel motion picture on "Diabetes and the Development of Insulin" was shown through the courtesy of the Eli Lilly and Company.—News Clipping.

Logan County Medical Society had as its guest speaker on April 6 Dr. Karl Figley, Toledo, who addressed the society on "Treatment of Hay Fever and Pollen Asthma".—News Clipping.

Marion County—The regular meeting of the Academy of Medicine of Marion was held April 3 at the Marion City Hospital. The guest speakers were Dr. E. I. McKesson, Toledo, and Dr. I. A. Bottenhorn, professor of dental pathology, Ohio State University. More than 80 members and guests were present. Dr. McKesson spoke on "Anesthesia in Medicine and Dentistry" and Dr. Bottenhorn on "Pulp and Pulp Canal Infections". Dr. McKesson compared postoperative mortality following the use of gas anesthetics and the use of ether or chloroform, stating that statistics which he had gathered favored the use of gas. He stressed the necessity for proper medication before an operation as essential to the welfare of the patient and to better administration of the anesthetic. He explained with charts the various stages of anesthesia and the signs to be used by the physician or dentist in checking the condition of the patient. Dr. Bottenhorn declared dentists should work on the treatment of root canal infection instead of resorting to premature extraction. Physicians, dentists and nurses of Marion County and many surrounding counties attended the meeting.—J. W. Jolly, M.D., secretary.

Mercer County Medical Society met on March 9 in Celina with Dr. P. I. Tussing, Lima, as guest speaker. He spoke on "The Heart".—News Clipping.

Seneca County Medical Society was entertained by Fostoria physicians at a dinner March 13 at the Hays Hotel, Fostoria. About 30 members were present. The guest speakers were Dr. Fred Douglass, Dr. L. A. Levison and Dr. I. J. Applebaum, all of Toledo.—News Clipping.

Van Wert County Medical Society in session April 3 was addressed by Dr. B. L. Good, Dr. J. B. Sampsell and Dr. L. M. Githens on "Pre and Post Operative Care of the Surgical Patient".—Bulletin.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

April 6—Surgical Section. Program: "The Treatment of Acute Pancreatic Necrosis", Dr. L. F. Smead; discussants, Dr. F. M. Douglass and Dr. E. J. McCormick.

April 13—Medical Section. Program: Symposium on Asthma. "General Considerations", Dr. Richard M. McKean, Detroit; "Bronchoscopic Findings", Dr. Wadsworth Warren, Jr., and Dr. Arthur E. Hammond, Detroit; "Pathologic Findings", Dr. Bernhard Steinberg, Toledo; "Sinus Disease in Asthma", Dr. James M. Robb, Detroit.

April 20—Section on Pathology, Experimental Medicine and Bacteriology. Program: "Bacteriaphage", Dr. N. W. Larkin, Lansing, Michigan.

April 27—General Session. Program: "Deficiency Diseases of Adults", Dr. M. A. Blankenhorn, Cleveland.

Sandusky County Medical Society was addressed on March 9 by Dr. R. E. Boice, Toledo, on "General Practitioners and Eye Specialists".—Charles J. Wehr, M.D., secretary.

Wood County Medical Society at its monthly dinner meeting March 15 at the Women's Club, Bowling Green, was addressed by Dr. James B. Rucker, Dr. Thomas Owens and Dr. Thomas Heatley, all of Toledo. Dr. Rucker discussed "Amebiasis, A Public Health Menace". A paper on "Etiology, Diagnosis and Treatment of Amoebic Dysentery" was read by Dr. Owens. Dr. Heatley spoke on "Fractures of the Skull".—News Clipping.

Fifth District

Ashtabula County Medical Society met in regular session March 20 at Hotel Ashtabula, Ashtabula. Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, discussed the question of medical care for the indigent and reviewed developments in the plan set up by the State Relief Commission. Following his talk, the society voted to protest to the Governor the attitude of the relief

commission and ask that the medical profession be given greater and more cooperative consideration by the commission. Dr. H. J. John, Cleveland addressed the society on "Present Status and the Factors in the Precipitation of Diabetes".—A. M. Mills, M.D., secretary.

Lake County Medical Society held its regular meeting on March 27 at the Lake County Memorial Hospital. Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, was present and spoke on organization and economic matters. Dr. Richard Dexter, Cleveland, addressed the society on "Left Ventricular Failure".—Mabel L. Pearce, M.D., secretary.

Lorain County Medical Society held a dinner meeting April 10 at the First Presbyterian Church, Lorain. The guest speakers were Dr. W. J. Gardner and Dr. John Tucker, both of Cleveland. Dr. Gardner presented a paper on "The Treatment of Late Results of Cranial Trauma". Dr. Tucker discussed "Some Unusual Conditions Producing Abdominal Pain".—Bulletin.

Sixth District

Union Medical Association comprising the counties of the Sixth Councilor District met at Kent State College, Kent, on April 11. Included on the program were the following addresses: "Presentation of a Universal Polycystic Kidney", Dr. H. G. Beeson, Wooster; "Pituitary Headache", Dr. W. M. Skipp, Youngstown; "The Development of Roentgenological Diagnosis by Contrast Media", Dr. B. H. Nichols, Ravenna; "Modern Aspects of Cardio-Vascular Disease", Dr. R. W. Scott, Cleveland; "The Endocrines", Dr. H. L. Reinhart, Columbus.—Bulletin.

Holmes County Medical Society held a dinner meeting April 4 at the Smith Hospital, Millersburg, at which the attorneys of the county were guests. The principal speaker was Dr. Walter G. Stern, Cleveland, who spoke on "The Doctor in Court".—News Clipping.

Mahoning County Medical Society held its Seventh Annual Post Graduate Assembly on April 28 at Hotel Ohio, Youngstown. The program was presented by the following faculty members from McGill University: Dr. J. C. Meakins, Dr. Wilder G. Penfield, Dr. John R. Fraser, and Dr. J. B. Collip. Dr. Meakins discussed, "Rheumatic Fever Considered as a Specific Infectious Disease; Its Prognosis and Treatment" and "Chronic Non-Tuberculous Pulmonary Disease". Dr. Collip spoke on "Recent Advances in Anterior Pituitary Physiology". Dr. Penfield discussed "Management of Head Injury, Early and Late" and "Classification and Management of Epilepsy". The papers presented by Dr. Fraser were on "The Inflammatory Pelvis" and "Hemorrhage in the Last Trimester of Pregnancy". Members of the post-graduate committee of the society which arranged for the assembly were: Drs. James Brown, chairman, M. H. Bachman, P. L. Boyle, J. E. L. Keyes, Sam Klatman, F. F. Monroe, M. D. Neidus and J. M. Ranz.

Portage County Medical Society met April 5 at the office of Dr. W. B. Andrews, Kent. The plan of medical care for the indigent was discussed. Dr. James G. Kramer, Akron, was the guest speaker, discussing "The Present Status of Serum Therapy in Children".—Bulletin.

Stark County Medical Society and the Canton Medical Library Society held a joint meeting at the Elks' Club, Canton, on March 23 when a sound movie, "Milestones in Medical Research" was shown.—Bulletin.

Seventh District

Belmont County Medical Society, in session April 12 at Bellaire, was addressed by Dr. Howard G. Wieler, Wheeling, West Va., on "Orthopedics in General Practice".—News Clipping.

Columbiana County Medical Society was addressed by Dr. William H. Bunn, Youngstown, at its meeting March 13 at Lisbon. Dr. Bunn discussed "Cardiac Irregularities and Treatment".

At its regular meeting April 11 at Lisbon, the society was addressed by Dr. A. B. Cloak, Rochester, Pa., on "Kidney Diseases".—News Clipping.

Tuscarawas County Medical Society had as its guest speaker on April 12, J. S. Hare, an attorney, who spoke on "Medical Jurisprudence".—Bulletin.

Eighth District

Athens County Medical Society was addressed by Dr. Charles J. Shepard, Columbus, at a dinner meeting on April 2 at Nelsonville. Dr. Shepard spoke on "Eczema". Twenty-one members and guests were present.

The March meeting of the society was held March 5 at Athens at which Dr. T. H. Morgan presented a paper on "Management of Head Injuries".—News Clipping.

Fairfield County Medical Society met April 10 at the Crystal Springs Inn near Sugar Grove. The guest speaker was Dr. J. Mitchell Dunn, Columbus, who discussed "Head Injuries".—News Clipping.

Guernsey County Medical Society met April 5 at the Berwick Hotel, Cambridge. Dr. M. C. McCuskey, Senecaville, addressed the society on "Orthopedics".

At its meeting on March 15, the society was addressed by Dr. C. C. Headley on "Some Common Mistakes Made by the General Practitioner in the Treatment of Eyes".—O. R. Jones, M.D., correspondent.

Muskingum County—The Academy of Medicine of Muskingum County held a dinner meeting April 4 at the University Club, Zanesville. The

guest speaker was Dr. F. C. Anderson, superintendent of the Ohio State Sanatorium, Mt. Vernon.

On March 7, the academy and the Muskingum County Bar Association held a joint meeting at the University Club. Following a dinner, the guests were addressed by Common Pleas Judge H. M. Whitcraft, Logan, and Dr. C. M. Rambo, president of the academy, on "The Doctor as the Lawyer Sees Him" and "The Lawyer as the Doctor Sees Him", respectively. Dr. E. R. Brush presided as toastmaster.—Bulletin.

Washington County Medical Society in session March 14 at Marietta was addressed by Dr. A. Howard Smith on "Historic Medicine", and Dr. S. A. Cunningham on "Toxic Goiter".—Bulletin.

Ninth District

Hocking County Medical Society held its regular meeting March 22 at Logan. Following a luncheon, Dr. V. V. Smith, Ironton, gave an interesting talk on "Ambulatory Treatment of Hemorrhoids".—M. H. Cherrington, M.D., secretary.

Scioto County—The Hempstead Academy of Medicine was addressed on April 9 by Dr. Ralph F. Massie, Ironton. His subject was "The Successful Treatment of Varicose Veins and Their Complications".—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)
(George J. Heer, M.D., Secretary Pro Tem)

April 2—General Session. Program: "Some Interesting Urological Cases", Dr. William N. Taylor; discussants, Dr. Hugh Baldwin and Dr. Frank W. Harrah.

April 9—General Session. Program: "Newer Developments in Endocrinology With Special Reference to Hypogonadism in the Male", Dr. E. Perry McCullagh, Cleveland.

April 16—General Session. Program: Periodic Health Lectures. "Introduction", Dr. A. A. Hall; "Immunology", Dr. Paul Ross; "Heart", Dr. E. E. Campbell; "Cancer", Dr. Roy Krigbaum; "Tuberculosis", Dr. Louis Jentgen.

April 23—General Practitioners' Section. Program: An Unusual Case Report. "Case History", Dr. E. E. Smith; "Discussion", Dr. E. E. Campbell; "Necropsy", Dr. H. L. Reinhart.

Crawford County Medical Society was addressed by Dr. Robert C. Austin, Dayton, on April 2 at the Bucyrus City Hospital. His subject was "Intestinal Obstruction".—C. A. Lingenfelter, M.D., correspondent.

Knox County Medical Society met March 29 at Mt. Vernon. The guest speaker was Dr. Wells H. Teachnor, Columbus, who discussed "Mesenteric Lymphadenitis".—News Clipping.

Pickaway County Medical Society in session April 6 was addressed by Dr. M. E. Millhon and Dr. H. E. Boucher, Columbus. Both discussed "Diabetes".—News Clipping.

At the March 15 meeting of the society, members of the Ross and Fairfield County societies were guests. The guest speakers were Dr. George P. Sims, Columbus, who spoke on "General Considerations of Radiation Therapy", and Dr. Charles F. Turner, Columbus, who discussed "Chorion Epitheliomia, Hydatid Mole and Deciduoma".—E. R. Austin, M.D., secretary.

Ross County Medical Society was addressed on March 1 by Dr. C. J. Straehley, Cincinnati, on "Angina Pectoris".—News Clipping.

OSMJ

Plan Degree for Nurses

Acting President Winfred G. Leutner of Western Reserve University, Cleveland, has announced that starting in September, the School of Nursing will become one of the graduate professional schools of the University. A student on admission must have completed a course leading to Bachelor's Degree in Arts, Science or Philosophy, in a college of approved standing. Upon completion of its course, graduates will receive the degree of Bachelor of Nursing. Miss Marion G. Howell, dean of the School of Nursing, says that the course can be completed in thirty-three months. The School will accept a few "seniors in absentia" from college, whose college courses have been planned to prepare for graduate work in nursing, just as the School of Medicine accepts such students, according to Miss Howell.

OSMJ

1935 Tri-State Meeting to be in Lima

The 1935 session of the Northern Tri State Medical Association will be held in Lima, probably in April. Lima was awarded the next meeting of the association at the 1934 meeting held April 10 at Flint, Michigan. Officers for the ensuing year are Dr. H. F. Randall, Flint, president; Dr. E. P. Gillette, Toledo, vice president; Dr. G. E. Jones, Lima, secretary, and Dr. P. N. Sutherland, Angola, Indiana, treasurer. The committee on arrangements for the Lima meeting is composed of Dr. E. B. Pedlow, Dr. W. W. Beauchamp and Dr. Burt Hibbard, all of Lima.

OSMJ

Dayton—Dr. Owen F. Deathridge has succeeded Dr. Frank N. Gordon as chief medical officer at the Dayton Veterans Hospital. Major Deathridge formerly was chief of the staff of the tuberculosis section at the hospital and has been located in Milwaukee for the past few years.

OSMJ

Withamsville—Dr. Cass A. Bennett recently celebrated his 87th birthday. He has been in practice for the past 56 years.

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Prompt and Full Report

Deaths in Ohio

William R. Abbott, M.D., Cincinnati; Miami Medical College, Cincinnati, 1908; aged 50; former member of the Ohio State Medical Association and the American Medical Association; died March 25 of pneumonia. Dr. Abbott was a native of Cincinnati and had practiced there since graduation from medical school. He was a member of the staff at St. Mary's Hospital. Surviving are his widow and one son.

George Frederick Bainter, M.D., Strasburg; Ohio Medical University, Columbus, 1896; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died March 31 following an extended illness. Dr. Bainter was former mayor of Strasburg and former Tuscarawas County coroner. He was a World War veteran and a member of the American Legion. Surviving are one son, four brothers, including Dr. R. B. Bainter, Zanesville, and Dr. H. H. Bainter, Coshocton, and two sisters.

S. Hilton Buker, M.D., Killbuck; Medical College of Ohio, Cincinnati, 1887; aged 69; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 8 of Bright's disease. Dr. Buker had practiced at Killbuck since 1909. He belonged to the Masonic, Odd Fellows and Maccabee lodges. Surviving are his widow, two sons, one of whom is Dr. Wallace Buker, Bellville, one daughter, two brothers and one sister.

Clarence J. Burns, M.D., Columbus; Ohio State University, College of Medicine, 1919; aged 39; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 17 at Tucson, Arizona. He was a member of the Catholic Order of Foresters, American Legion and Alpha Kappa Kappa fraternity. Surviving are his widow, his mother, one sister and two brothers.

Charles Edward Caldwell, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1884; aged 74; former member of the Ohio State Medical Association and of the American Medical Association; died March 23. Dr. Caldwell was a member of the Southern Surgical Association and former professor of surgery and anatomy at the University of Cincinnati, College of Medicine. One son survives.

Vernon G. Danford, M.D., Athens; Illinois Medical College, Chicago, 1900; aged 58; former member of the Ohio State Medical Association and the American Medical Association; died March 15 of heart trouble. For a number of years, Dr. Danford practiced in Trimble, his home town. He served in the World War and after the war, located in Glouster, later moving to Athens. He was a member of the Masonic and Elks lodges and the American Legion. Surviving are his widow, one son, Dr. Byron Danford, Athens, and six daughters.

George W. Darling, M.D., Portsmouth; Hospital College of Medicine, Louisville, Kentucky; 1885; aged 88; died March 16. Dr. Darling had practiced at Wellston and Gallipolis for many years before moving to Portsmouth several years ago. He was a member of the Masonic Lodge and Baptist Church. Surviving are his widow, four sons, one daughter, two brothers and three sisters.

Lauren E. Flickinger, M.D., Canton; Western Reserve University, School of Medicine, 1892; aged 65; member of the Ohio State Medical Association and the American Medical Association; died March 25 of a cerebral hemorrhage. Dr. Flickinger had practiced in Canton 37 years, having been located previously at North Industry and Salem. He was a member of the staff at Aultman Hospital and of the Moose, Eagles and Maccabee lodges. Surviving are his widow and two sisters.

Julius Goldfinger, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1895; aged 62; former member of the Ohio State Medical Association and the American Medical Association; died March 20 of heart disease. Dr. Goldfinger had practiced in Cleveland since 1896 and had been a member of the staff at Fairview Hospital for the past 25 years. His widow and one daughter survive.

George D. Grant, M.D., Springfield; Pulte Medical College, Cincinnati, 1878; aged 78; member of the Ohio State Medical Association and the American Medical Association; died March 6. Dr. Grant, a native of Springfield, was the oldest practicing physician in that city. He was a former member of the board of education and an active member of the Congregational Church. His widow, two sons and one sister survive.

Reverdy Edgar Hughson, M.D., Orient; McGill University, Faculty of Medicine, Montreal, 1896; aged 62; member of the Ohio State Medical Association and the American Medical Association; died March 24 of pneumonia. Dr. Hughson was first assistant physician at the State Institution

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for Feeble Minded at Orient. He had practiced at Bluffton for 26 years before going to that institution in 1926. Dr. Hughson was a World War veteran. His widow, one son and one brother survive.

John F. Haas, M.D., Kelly Island; Starling Medical College, Columbus, 1896; aged 70; died February 27 of heart disease. Dr. Haas was a former resident of Zanesville but had been located on Kelly Island since 1923. His widow, two sons and one daughter survive.

Jacob A. Haerr, M.D., Cincinnati; Pulte Medical College, Cincinnati, 1881; aged 74; died March 16. Dr. Haerr, a native of Springfield, had practiced in Cincinnati for more than 50 years. His widow survives.

Charles F. Keyser, M.D., Cuyahoga Falls; Baltimore Medical College, Batlimore, 1896; aged 73; member of the Pennsylvania State Medical Association and the American Medical Association; died March 10. Dr. Keyser had been a resident of Cuyahoga Falls for the past four years, moving there from Duquesne, Pa. His widow, three daughters, two sons, two brothers and one sister survive.

George Morrison Logan, M.D., Akron; Rush Medical College, Chicago, 1909; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 21 of heart disease. Dr. Logan was a native of Manhattan, Kansas. He located in Akron after leaving medical college. Dr. Logan was a former secretary, vice president and president of the Summit County Medical Society. During the World War he was a captain in the medical corps. He leaves one son and one daughter.

Berlie W. Mercer, M.D., Tiffin; Eclectic Medical College, Cincinnati, 1897; aged 69; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 9 following a stroke of paralysis. Dr. Mercer had practiced in Tiffin for many years and was a former president of the National Eclectic Medical Society. He was a member of the Masonic Lodge and Junior Order. Surviving are his widow, one son, one daughter and three sisters.

Charles W. Mercer, M.D., Dillonvale; Starling Medical College, Columbus, 1891; aged 65; died March 10 of heart disease. Dr. Mercer had practiced at Dillonvale for 44 years. His widow, three daughters, one sister and two brothers survive.

Willis M. Metzler, M.D., Vanlue; Starling Medical College, Columbus, 1895; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 14. Dr. Metzler was a native of Findlay. His widow survives.

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University, Columbus, 1902; aged 61; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 12 of heart disease. Dr. Mizer had practiced in Columbus for 32 years. He belonged to various Masonic bodies. His widow and his father survive.

Allen F. Mowery, M.D., Ashland; Cleveland College of Physicians and Surgeons, 1886; aged 76; former member of the Ohio State Medical Association and the American Medical Association; died February 27. Dr. Mowery retired from active practice two years ago, shortly after celebrating the 50th anniversary of his entrance into medicine. He had been located in Ashland since 1920, having practiced at Reedsburg previously. Two sons survive.

James W. Reese, M.D., Cleveland; Ohio State University, College of Homeopathic Medicine, 1915; aged 45; former member of the Ohio State Medical Association and the American Medical Association; died March 2. Dr. Reese practiced at Elyria and New London before moving to Cleveland 11 years ago. During the World War, he served 13 months overseas in the medical corps. His widow, two sons, his mother and two brothers survive.

Orville A. Rhodes, M.D., Salem; College of Physicians and Surgeons, Baltimore, 1882; aged 73; former member of the Ohio State Medical Association and a former Fellow of the American Medical Association; died March 16. Dr. Rhodes began practice at Lowellville. He later practiced at Washingtonville and Asheville, N. C., before locating in Salem about 1898. One son, two brothers and one sister survive.

R. Calvin Richie, M.D., Powell; Columbus Medical College, 1882; aged 78; died March 26. Dr. Richie had practiced in Delaware County for the past 40 years. He belonged to the Presbyterian Church and Odd Fellow Lodge. His widow, two sons, two daughters and two brothers survive.

Albert S. Rudy, M.D., Lima; Medical College of Ohio, Cincinnati, 1884; aged 79; member of the Ohio State Medical Association and the American Medical Association; died April 6. Dr. Rudy, a former member of the Council of the Ohio State Medical Association, was a native of Allen County. He began practice at Lafayette, moving to Lima in 1890. Dr. Rudy belonged to the Methodist Episcopal Church, Masonic and Odd Fellow lodges. He was former city health officer, former member of the board of education; former examiner for the U. S. Pensions Board; one of the organizers of the Lima City Hospital, and former president and secretary of the Northwestern Ohio Medical Association. His widow, one daughter, one son, and one sister survive.

John Denver Siddall, M.D., Carey; Eclectic Medical College, Cincinnati, 1898; aged 61; member of the Ohio State Medical Association and the American Medical Association; died March 15 of pneumonia. Dr. Siddall was a veteran of the Spanish-American and World wars. He practiced at Mt. Blanchard and Columbus Grove before locating in Carey in 1919. He was a native of Hancock County. Surviving are his widow, one brother and five sisters.

James Edgar Studebaker, M.D., Urbana; Pulte Medical College, Cincinnati, 1879; aged 78; former member of the Ohio State Medical Associa-



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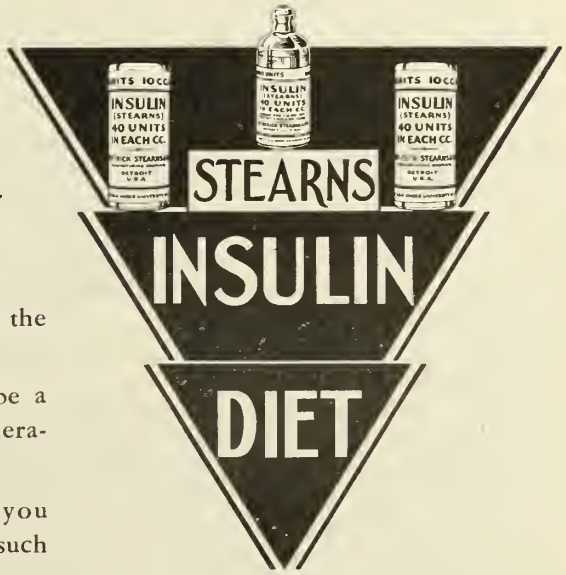
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tion and the American Medical Association; died March 7. Dr. Studebaker was a native of Urbana. He was formerly a member of the science staff at Wittenberg College and practiced in Springfield for many years. He returned to his old home several years ago. His widow survives.

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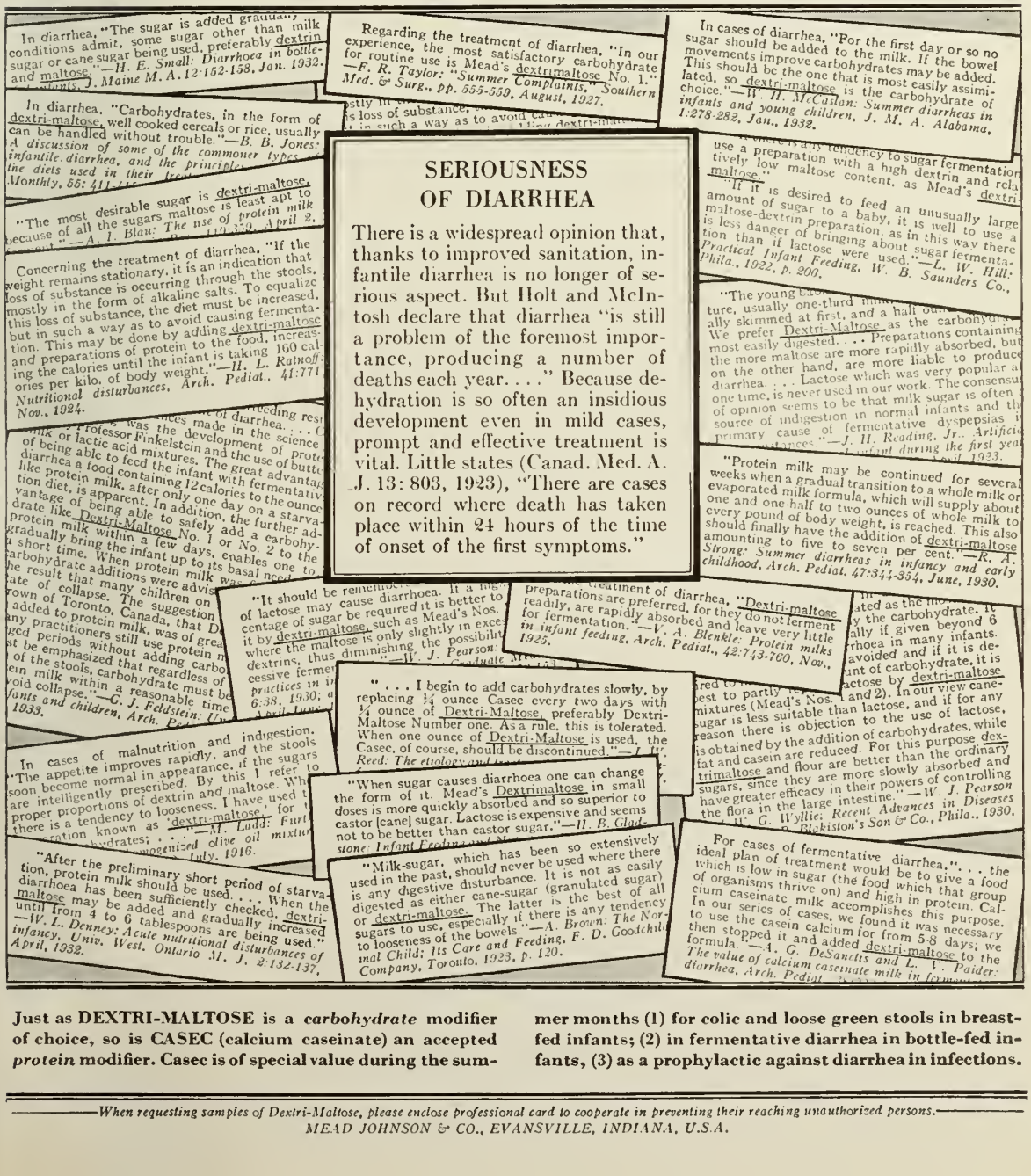
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Number 6

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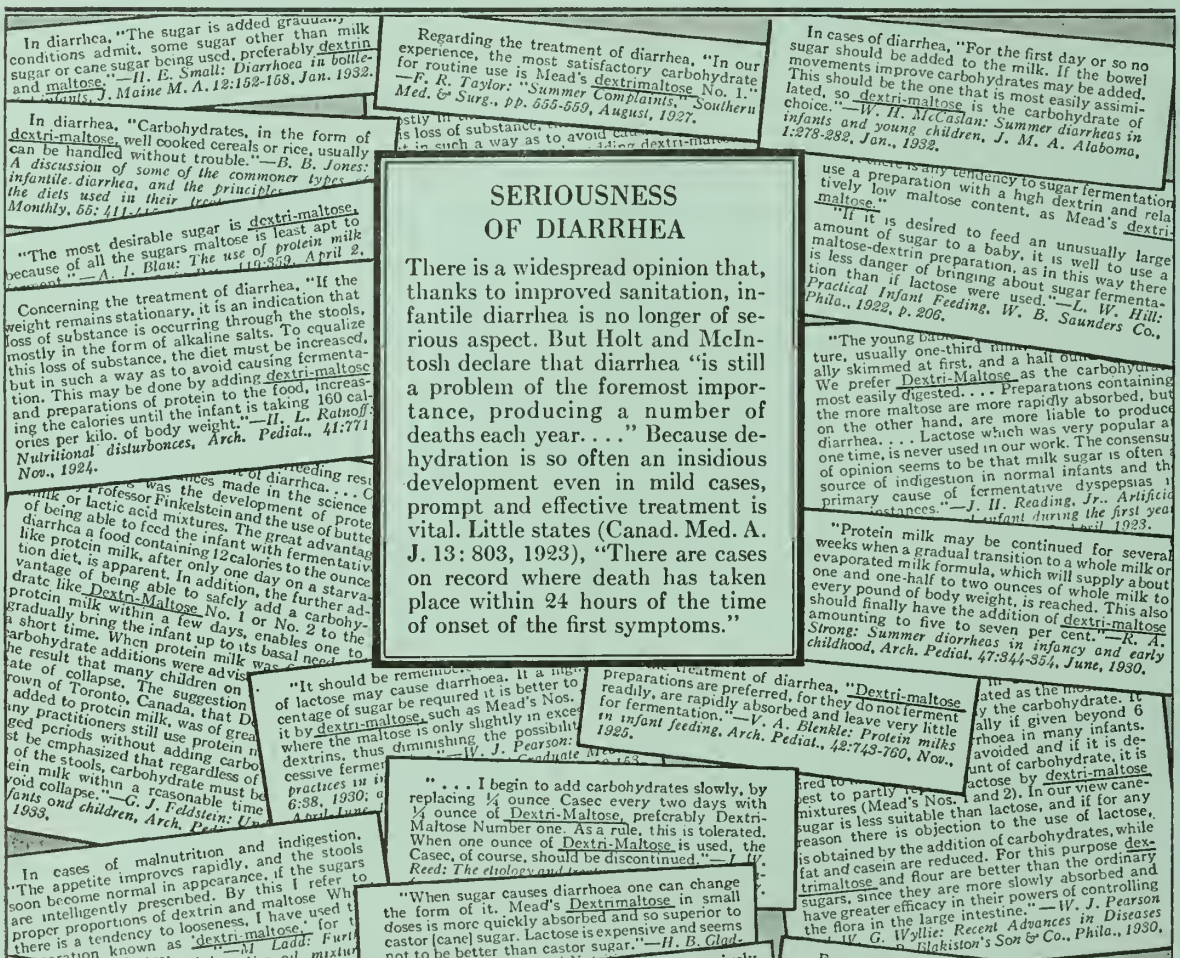
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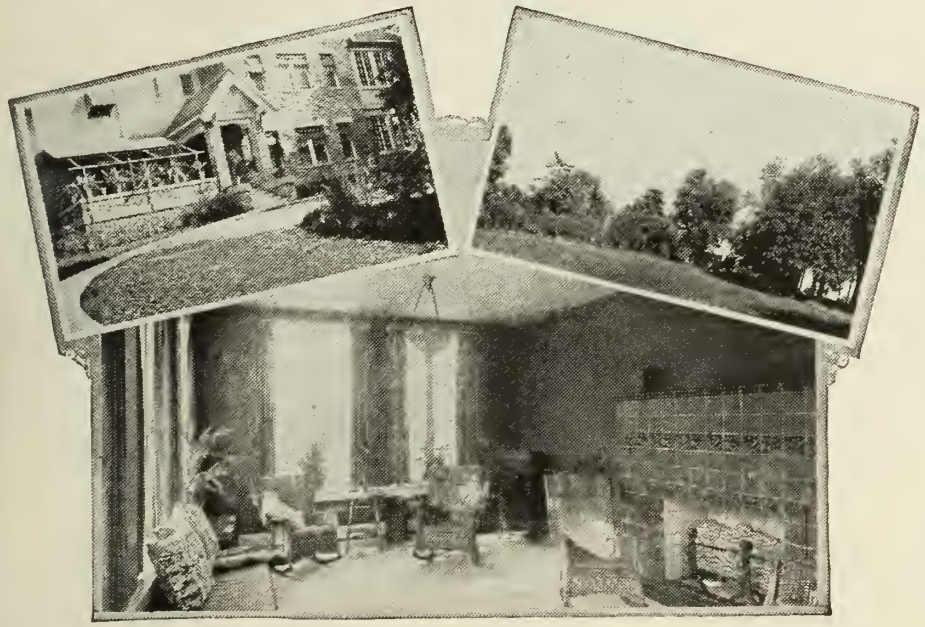
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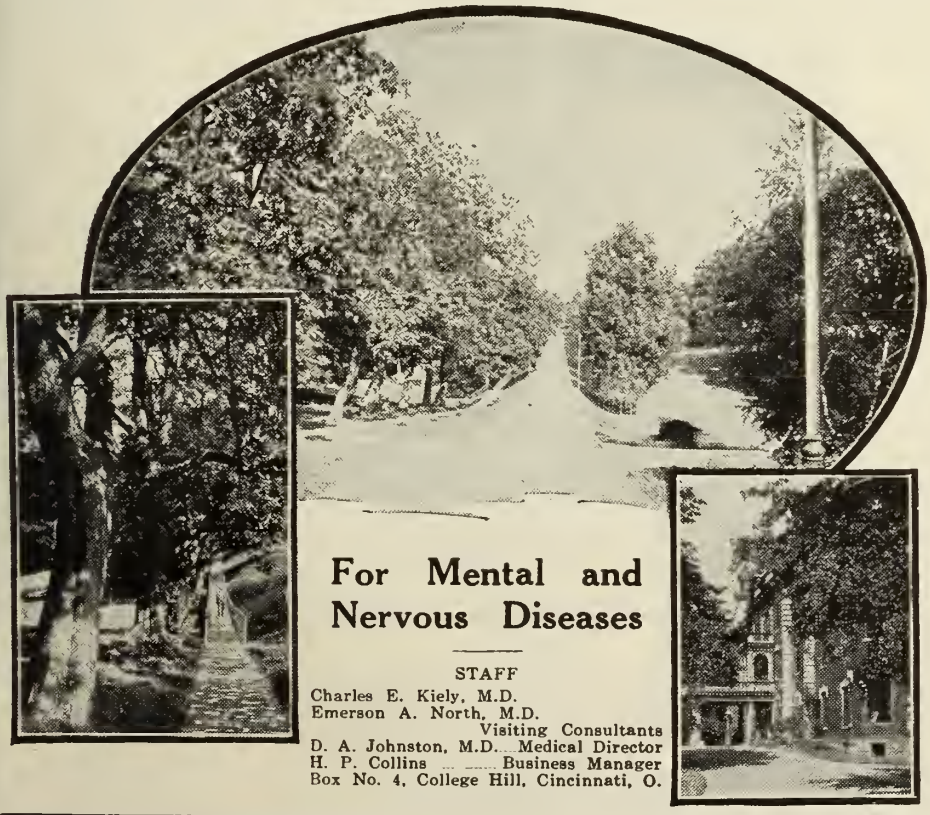
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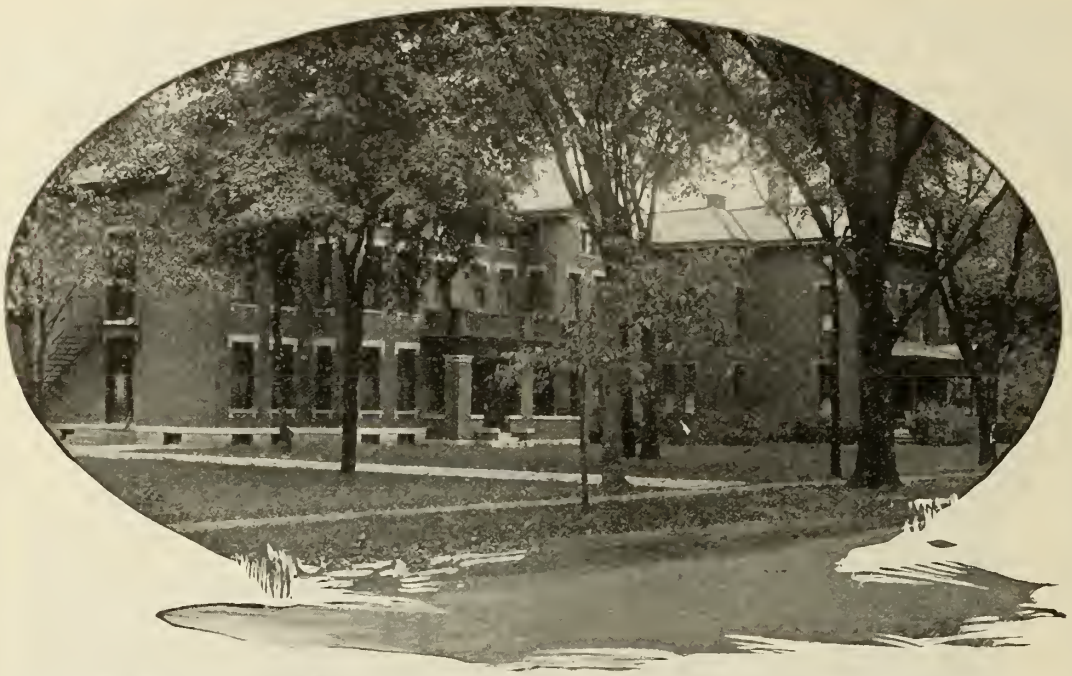
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[1] Morse and Talbott, Diseases of Nutrition and Infant Feeding, pgs. 214, 215.

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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Elsewhere in this issue of *The Journal* is published information relative to the program and entertainment features of the annual session of the American Medical Association in Cleveland, June 11-15th.

A. M. A. Meeting In Cleveland

Every physician realizes, or should, that the annual session of the American Medical Association is without an equal as a medical gathering. This year's meeting promises to be even superior to those of the past.

Moreover, every Ohio physician should take pride in the fact that the medical profession of this state is to be host to this great congress of medical men. Every Ohio physician who can possibly do so will want to attend in order to bring his knowledge of medical matters up to date and to assist his Cleveland colleagues in extending the hospitality of the profession of this state to those from other parts of the nation.

Ohio physicians desiring to take advantage of this splendid opportunity to attend the greatest annual medical gathering of the world without leaving the confines of their own state should remember that only Fellows, affiliate, associate and honorary Fellows, and invited guests of the American Medical Association may register and take part in the work of the sections.

Fellows of the Scientific Assembly are those members who have, on the prescribed form, applied for fellowship, subscribed to the *A.M.A. Journal*, which subscription constitutes the fellowship dues for the current year. Thus the annual fellowship dues provide a subscription to *The Journal* for one year. Members in good standing in component county medical societies, who are therefore members of constituent state medical associations and of the American Medical Associations, are eligible to apply for fellowship.

Physicians who are not fellows of the A.M.A. but who desire to become so before the date of the Cleveland meeting, should secure an application blank immediately from the headquarters office of the A.M.A., 535 North Dearborn Street, Chicago. It will be possible for members of the A.M.A. to qualify as Fellows at Cleveland during the meeting, but to assist in expediting registration, members are urged to apply for fellowship before leaving home and in time to insure receipt of a fellowship card from A.M.A. headquarters. When registering, all Fellows should present their fellowship cards.

Fellowship in the American Medical Association is at all times, we believe, one of the best investments a physician can possibly make.

Fellowship in the A.M.A. should this year appeal more strongly than ever before to Ohio physicians if for no other reason than because it is the key to an opportunity most of them covet but of which, many are not able to take advantage—participation in the annual session of the American Medical Association.

—OSMJ—

As was to be expected, suits for alleged malpractice and threats of suits against physicians have increased in number during the long period of unsettled economic conditions.

The Growing Menace of Malpractice Suits and Threats

Experience has shown that physicians are in greater danger from imposters and swindlers, imbued with the urge for "easy money", in times of financial distress when the field of operation for such gentry is necessarily limited and a greater number of individuals are willing to become tools in the hands of unscrupulous and greedy attorneys in return for promises of a 50-50 cut in whatever may be obtained from physicians through blackmail or extortion.

For this reason, it is especially important now that every physician provide himself with adequate protection against racketeering of this type.

First, every physician eligible to membership in medical organization should affiliate immediately with his county medical society and the Ohio State Medical Association in order that he may benefit from the medical defense plan of the State Association, the two-fold purpose of which is to prevent so far as possible unjust suits for alleged malpractice and aid in the defense of physicians named defendants in such actions. Membership in medical organization and incidentally participation in the medical defense plan is one of the best safeguards at the com-

mand of the physician against malpractice racketeering.

Second, every physician who carries indemnity insurance against alleged malpractice and other claims arising from his professional activity should assure himself that he is insured with a company of undisputable integrity and which is financially sound; and, moreover, that the policy which he carries covers the situations for which he desires protection.

We recommend that every physician heed the advice of Dr. J. E. Tuckerman, chairman of the Committee on Medical Defense of the State Association, regarding indemnity insurance policies and their coverage. Writing in a recent issue of *The Bulletin of the Academy of Medicine of Cleveland*, Dr. Tuckerman said:

"Rates for indemnity insurance against alleged malpractice are up. Premiums are about one-third more than last year; apparently carriers find business unprofitable. Insurance companies are primarily interested in profits; physicians primarily want adequate protection for professional reputation as well as for their purse. A suit alleging malpractice is not merely a demand for a cash indemnity, it is an attack on the professional integrity of the physician.

"The physician has a right to know whether his policy protects him against all claims arising from his professional activity or only seems so to do. He should know the record of the insuring companies. Are they wont to make nominal settlements to save financial expense at the expense of the physician's reputation? Do they take advantage of unproven allegations, criminal acts to renege on their obligations to defend? Does the policy protect him against allegations of false commitment, personal restraint, assault, slander, libel, anesthesia hallucination, cross suits occasioned by suits to collect, and against any and all contingencies arising out of the professional relationship of physician and patient? The physician should know the coverage of his policy and should insist on defense rather than consent to nominal settlements."

In recent months, complaints have been registered by some physicians regarding the tendency on the part of some insurance companies to attempt to avoid liability on technicalities or on the ground that the physician has violated some provision of the policy contract. Moreover, there has been an increasing tendency on the part of some indemnity companies to settle suits out of court for nominal amounts. This, in effect, is an acknowledgement of a physician's fault without giving him an opportunity to clear himself which is, as the record shows, the ultimate outcome of the overwhelming majority of malpractice cases tried.

Instances of this nature should be reported to the Committee on Medical Defense of the State Association which will make every effort to see that a member's rights under his insurance contract are protected and that a defendant physician is given every possible opportunity to preserve his reputation and professional standing.

As Dr. Tuckerman pointed out, "increased rates should mean increased protection". It is up to the medical profession to insist that this be given and that loopholes are eliminated from indemnity policies.

At the same time, every physician should remember that he has important responsibilities to meet in efforts to clean up the malpractice situation.

Some members of the profession have failed to give their wholehearted support and cooperation to the medical defense plan of the State Association. They have failed to heed repeated warnings concerning unguarded remarks about their fellow practitioners and their work which is conceded to be the primary cause of at least 75 per cent of suits for alleged malpractice. Malpractice suits and threats cannot be kept at a minimum unless physicians make a united effort to solve this problem.

— OSMJ —

Public and Civic Action

"Never in our memory, so it appears to us, has the political primary been of such great importance as at the present time", was the timely observation made recently by the editor of the *Indiana State Medical Journal* in discussing some of the political and legislative questions affecting the physician as an individual and the medical profession as a group.

Heeding this admonition, the truth of which is apparent, Ohio physicians would do well to focus their attention in advance toward the primary elections in Ohio, to be held Tuesday, August 14, when party candidates for state and county offices and seats in the Ohio Legislature and United States Congress will be chosen. Activity should be undertaken *before* June 15, which is the dead-line for filing of declarations of candidacies.

Right now is the time for those interested in good government and sound legislation to get busy, find out as much as possible about those running for public offices, and study the campaign issues so that they will be in a position to vote intelligently.

Present indications are that an unprecedented number of candidates will be in the field by the time of the primaries. In all probability the majority of those now holding office will seek renomination. Many candidates will be running for public office for the first time. The campaigns for the most part will be based on issues involving in some form or another important

social, economic and governmental problems which have combined to make the present period one of the most critical in the history of the state and nation.

Physicians, as leading citizens in their respective communities, interested in good government and sound legislation, and as members of an organization one of the important purposes of which is an active interest in civic, governmental and legislative developments that in any way affect public health, scientific medicine and medical practice, should be more than onlookers in the ensuing primary campaigns.

Unlike many groups of voters who are compelled to rely upon hearsay information regarding candidates for office, physicians are fortunate in that they have available information and the record on those seeking re-election to public positions. This does not mean that medical organization as such should become involved in political controversies or officially endorse or condemn political candidates. In fact, medical organization would only weaken the strong position it now holds in having taken a non-political. unselfish and humanitarian interest in medical and health matters, if it were to take part in party politics. Naturally, physicians as individuals are at liberty to take as active a part in political affairs as they deem advisable. In fact, physicians as leading and influential citizens of their respective communities have in the past had a too passive attitude, in general, toward civic and political questions. Greater activity by them in the future should be encouraged.

A function of medical organization in politics is that of promoting cordial and cooperative relationships between the profession and public officials who in any way through their official acts have to do with public health, medical service or scientific medicine.

Each time the electorate is called upon to select candidates for or elect persons to public offices the medical society in each county is afforded an opportunity to be of distinct service to its members and the profession of the state generally. It is the duty of the officers and proper committees of each county medical society to stimulate an active interest in primary and general elections among the membership. They may properly disseminate information regarding candidates, their qualifications, attitude and record, if any.

Because of the numerous social, economic and governmental developments affecting medical practice and public health that have taken place during recent months and the prospects for even more important developments in the near future, it is especially vital that the medical profession of Ohio take a more direct interest in public affairs, including matters of legislation and governmental administration, now than ever before.

The great influence of governmental developments on the practice of medicine should be apparent to every physician. Unless the reins of government are retained or placed in the hands of those with sound views on medical and health matters, the medical profession, as well as the public, will suffer.

Activity on the part of the medical profession will be necessary to make the influence of the profession felt in legislative and governmental activities. Now is the time for physicians to concern themselves and become factors in the approaching primaries and general election. Candidates should be contacted and interviewed. The records and qualifications of office-seekers should be analyzed. Physicians should stimulate among their friends and acquaintances an active interest in political matters and interest themselves in bringing about the nomination and election of candidates qualified and worthy of the public's confidence and responsibilities of public office.

— OSMJ —

Preventive Medicine In Private Practice

Reporting recently on some of the activities carried on by his department during 1933, a city health commissioner in Ohio indicates that he and his department have adhered to a sound policy with respect to differentiating between the duties and responsibilities of the public health official and the physician in private practice.

To quote from his report:

"The newest phase of work undertaken during the year was the special effort to get all younger children in the city immunized by their own physicians. This anti-diphtheria campaign we believe is but the beginning of a new policy which will make practical what has heretofore seemed a rather fantastic statement, namely: That every physician's private office will become a health center. Planned additional steps in this policy are: In addition to diphtheria immunization, smallpox, scarlet fever and other preventive treatments all performed by private physicians; treatment of a large majority of the indigent sick by private physicians; periodic health examination of all interested persons, also the examination of all children for school attendance. All this work could reasonably be done by private physicians, and that part for which the individual is not able to pay should be financed by the city. No doubt the institution of this plan will gradually take place over the period of the next two or three years. The result would be a saving of time in the school by reducing time now taken up for examinations; increasing the efficiency of children in school work by improving their health; insuring the very highest scientific medical service to the individual; in general, preventing the development of bureaucracy in public administration, and finally, the

greatest advantage to the medical profession and to the people at large would be in preventing further development in the field of state medicine".

The soundness and practical advantages of such a policy for all concerned are quite evident. Such a program is a worthy example for all public health officials.

At the same time, it should be noted that certain definite responsibilities are placed upon the shoulders of the medical profession some members of which, unfortunately, have been woefully lax and indifferent in taking part in public health activities of this nature.

Physicians of vision and judgment will readily see the advantages and benefits of programs which make the family physician the key-man in preventive medical service.

Complete responsibility for the public health program of any community cannot be delegated to either the medical profession or the health officer. It is a matter of intelligent and active cooperation on the part of both. The physician must be a practitioner of preventive, as well as curative, medicine. The health officer, if he is sincerely interested in discharging his obligations to the public, will subscribe wholeheartedly to the theory that more people will be reached and more beneficial service performed when more physicians in private practice participate in this program and are encouraged to take an active part in the functions of his department

— OSMJ —

An Historical Conference Is In Prospect

Not since before America's entry into the World War has there been so much talk of and agitation for some form of compulsory sickness insurance in this country as at the present time.

Because of acute economic conditions, which have been the excuses offered for many startling social and economic experiments, and as a result of the propaganda originating from the majority report of the Committee on the Costs of Medical Care, organized efforts to formulate some socialized system of furnishing medical care to a large proportion of the population have made more rapid advancement during the past several months than even the most optimistic supporters of such programs had expected.

The medical profession cannot ignore the fact that during the past few years the complete socialization of medicine has approached closer to the stage of reality in many communities, as well as the nation as a whole. Developments which have brought about serious and extensive invasion of the field of medical practice by government and by subsidized and commercial agencies have created the most serious situation the medical profession of this country has ever been called upon to face. It has no choice but to face the facts promptly and courageously and with as great unanimity as possible decide definitely its attitude toward the challenging problems now confronting it.

For that reason, it may be predicted that the forthcoming annual session of the American Medical Association in Cleveland, June 11 to 15 will be one of the most important, if not *the* most important, meetings ever held by organized medicine in this country. The serious questions confronting the profession are certain to be brought up for studious consideration, discussion and action. They should be. It is an appropriate time for a clarification of policies for the benefit of the uninformed; a definition of principles; and the formulation of a course of activity to guide the profession as a whole.

In view of recent important developments affecting medical practice and because of the acute economic situation existing among many members of the profession itself, plus the agitation being carried on by theorists, some groups within the profession are demanding a change in present policy.

To quote the editor of *The Journal of the American Medical Association* on the subject:

"There seem to be evidences that official bodies representing the medical profession in some of the states are interested in a change of this policy of the House of Delegates. It remains to be seen, therefore, whether the American medical profession, as represented by organized medicine through the House of Delegates, wishes to continue its policy of careful experimentation with new methods of medical practice, observing the ethics and traditions of medicine, or whether it is ready to endorse on a nation-wide scale some step toward the socialization of medical care. Obviously, the medical profession has never been confronted at an annual session with questions of greater moment for its determination."

Obviously, the Cleveland meeting will be something more than just another annual session. The responsibility confronting each member of the House of Delegates will be great.

We believe there are two main questions that must be decided:

Shall or shall not the medical profession in the name of expediency and under economic stress compromise on the principles and ideals that are the basis of medical practice?

Shall or shall not the physicians of America stick together, work in unison, actively support the efforts and programs of organized medicine, and endeavor to cultivate an attitude of tolerance, generosity and reasonableness in their relations with one another?

The answer to these may play a major part in determining the destiny of American medicine.

DIAGNOSIS AND PROGNOSIS OF TUBERCULOSIS IN CHILDREN

By A. GRAEME MITCHELL, M.D., and WALDO E. NELSON, M.D.,
CINCINNATI, OHIO

OF THE commoner differential diagnoses which the pediatrician or general practitioner is called upon to make, perhaps none is more difficult or lends itself less to exactness than does that of low-grade chronic infection with or without respiratory symptoms. Whether the respiratory system is involved in a given child and if so whether the infection is tuberculous or nontuberculous are questions that require answer. Every facility at our disposal must be used, since the case that is self-evident is rare. It does not follow that the diagnosis of tuberculosis in children is too complicated a procedure for the average well-informed practitioner, but there is the necessity for careful, complete examinations and intelligent analyses of the collected data.

An adequate examination should include a careful and detailed history, a thorough physical examination, roentgenograms of the chest, tuberculin tests and bacteriologic examination. While the isolation of tubercle bacilli is definite proof of tuberculosis, no other symptom or finding is sufficient by itself to establish a diagnosis. Therefore in the absence of bacteriologic confirmation, a careful analysis of the collected data becomes of great significance.

The taking of a complete history is the first step in diagnosis. In most instances it is better to obtain this in the absence of the child. Questionable points which the child can answer more accurately or more fully may be ascertained at another time. The history may be divided into two parts; first that relating to contact with open tuberculous infection and second, the subjective and objective symptoms.

While knowledge of association with persons suffering from open tuberculosis is strong supportive evidence of tuberculosis, it must be remembered that many parents will be unaware of such contact even when it exists. Furthermore, while tuberculous infection and disease are more frequent in children of families with open tuberculosis, there are many possibilities for infection outside the family. The detection of family infection is important not only from the standpoint of diagnosis, but also that there may be secured treatment for all those infected and that further spread of the disease may be prevented. It is inconceivable that the duty of a practitioner to a family or to the community is complete until he has established the "tuberculous status" of each member of a tuberculous family. Even though other members do not give a history of respiratory infections or of other symptoms suggestive of tuberculosis, they must be carefully examined and roentgenograms of the chest must be taken. The following illustrations support the validity of this statement. An infiltrative pulmonary lesion is shown in the roentgenogram (Fig. 1) of the child. There was no knowledge of contact. The roentgenogram of the chest of the mother (Fig. 2) showed a progressive pulmonary lesion and her sputum contained acid-fast bacilli.

The history may or may not be an aid in

V. W. Colored female eight months of age who had pneumonia in May, 1932. Slow resolution; tuberculin positive; no known contact.



Fig. 1. Roentgenogram taken 7-29-32. Shows exudative lesion in right hilus region extending into right base.

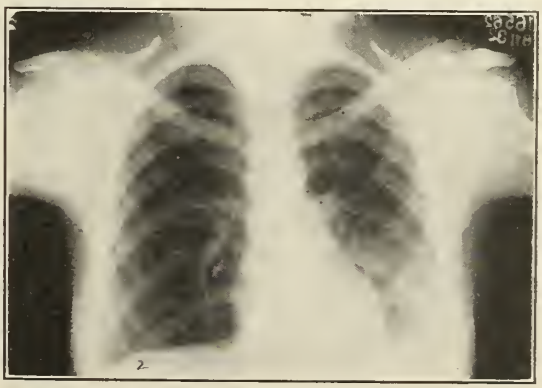


Fig. 2. Roentgenogram of mother, C. W., 19 years of age, taken on 6-11-32. Shows basal lesion of left side. Sputum positive.

Read before the Third General Session, Ohio State Medical Association, at the 87th Annual Meeting, Akron, September 7-8, 1933.

From the Children's Hospital, Cincinnati, and the Department of Pediatrics, University of Cincinnati.

Acknowledgment is made to Dr. Kennon Dunham and the Hamilton County Tuberculosis Sanatorium for permission to use several of the roentgenograms reproduced in this paper.



Fig. 3. Roentgenogram taken 8-20-31. Shows questionable pathology in cardiac region, which is demonstrated by lipiodal injection in Fig. 4.

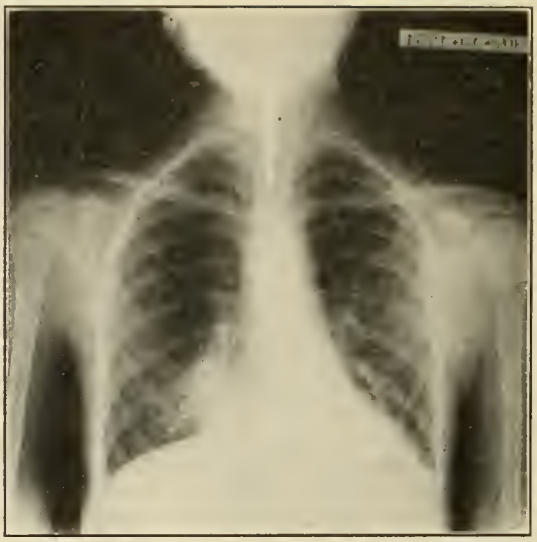


Fig. 4. Roentgenogram taken 10-10-31. Shows beginning clubbing of the bronchioles. This is probably a nontuberculous infection of the bronchiectatic type.

making the diagnosis. If the child is voluntarily brought to the physician there are apt to be symptoms present. If he is one of a group which is being routinely examined, he may have no complaint whatsoever and the family may be quite unaware that he is not perfectly well. It is exceptional to find the classical history consisting of known contact, loss of weight, fever and night sweats; such a situation suggesting, in fact, a fairly well advanced stage of the disease. Any one of these symptoms, however, is sufficient reason to warrant a complete examination. It must always be remembered that there may be obtained a history very suggestive of tuberculosis, including knowledge of contact, in a patient who is, in reality, suffering from chronic nontuberculous pulmonary infection.

CHRONIC NONTUBERCULOUS RESPIRATORY INFECTION

V. R. White girl nine years of age with a history of chronic respiratory infection which she has had since six years of age and which followed pertussis. Infection was characterized by a loose cough which was productive of some purulent sputum. One year after this initial infection she lived with her grandfather who had active tuberculosis and who subsequently died of this disease. Tuberculin reactions with repeated large doses of tuberculin have been persistently negative. Physical findings have been almost entirely in the left lower chest. (Figs. 3 and 4.)

The fact that tuberculous pulmonary disease is at times discovered in routine examinations, particularly on the roentgenogram of apparently symptom-free children, does not warrant undervaluation of the history. Rather should it stimulate further and more detailed queries regarding the child's activities, symptoms and habits. Perhaps the most common symptoms are those which are ordinarily associated with malnutrition, such as loss of weight or failure to gain, irritability and fatigue. Other symptoms include elevation of temperature, particularly in the late afternoon, and less often, cough, chest pain and night sweats. However, the clinician must not forget that it is quite commonly found that a well-nourished child, free from symptoms, may have pulmonary tuberculosis; under these conditions often of a minor nature or early in development. As a matter of fact, it has been demonstrated that subnormal weight is not more frequent in children with positive tuberculin reactions than in those with negative ones, and that underweight cannot be correlated to the graver lesions discovered by roentgenograms.

The physical examination should include more than the chest. Not only does tuberculosis frequently involve other parts of the body than the lungs, but it is essential to consider the child as a whole and not simply as a case of pulmonary disease.

In examining the chest it must be borne in mind that rather extensive infiltrative lesions may exist in the lungs but sufficient aerating tissue remain to permit normal breath sounds and to preserve the normal percussion note. Physical findings when present may vary from a slight suppression of breath sounds to the amphoric breathing produced by a cavity, and from an occasional click to persistent râles. The majority of primary infiltrative pulmonary lesions occur in the lower two-thirds of the lung, and this somewhat facilitates their detection. Extensive infiltrative lesions are apt to impair the percussion note, the degree depending upon their extent and particularly upon their proximity to the chest wall. The percussion note over pleural effusions and markedly thickened pleura resulting from an old pleurisy is dull to flat. The breath sounds over the infiltrative lesion may be normal to tubular in character, in contrast to suppression of them

over pleuritic areas. There are exceptions, of course, to this rule. The infiltrative process may be obscured by a pleurisy, or some factor such as occlusion of a bronchus may result in distant, suppressed or even absent breath sounds.

In the so-called epituberculosis, or nonspecific infiltration around a tuberculous lesion, it is generally stated that the percussion note is impaired, the breath sounds distant or suppressed, and râles absent. While there may be an infiltration of this nature, it is in our experience rare, and the physical signs of it by no means characteristic. It should be diagnosed only by roentgenograms, and preferably by serial ones followed over a long period of time.

Râles are commonly found in localized, progressive, infiltrative lesions and in disseminated lesions of tuberculous bronchitis and caseous broncho-pneumonia. They may vary from the fine, crepitant type to coarse rhonchi and are often more or less persistent.

The apical, secondary lesion which is so characteristic of adult tuberculosis is not found with any degree of frequency until the age of puberty, when it becomes the most common tuberculous lesion, especially in adolescent girls.

Miliary tuberculosis of the lungs may not be productive of localized physical findings until the terminal stage when fine, crepitant râles are heard throughout the chest and give the impression of being quite close to the ear. Before this time there may be only the symptoms of a severe, systemic infection, as fever, prostration and wasting.

Cavities may occur in progressive, primary lesions but are somewhat more apt to be deeply placed than are those found in the chronic adult lesions and, therefore, they may be more readily overlooked. If detectable by physical examination there will be found marked increase in the intensity of the breath sounds, perhaps to the extent of amphoric breathing; and accentuation of the spoken voice, particularly of whispered sounds.

Infection of the tracheobronchial lymph nodes is even more difficult to detect by physical examination than are parenchymal lesions. We must confess lack of confidence in our own ability to discover increased paravertebral dulness by percussion, nor have we found the so-called d'Espine's and Eustace Smith's signs to be of clinical value, nor to check with necropsy findings.

Roentgenograms are of great value in the diagnosis of tuberculosis of the lungs. The clinician should familiarize himself with the interpretation of roentgenograms and compare the information so gained with his clinical findings. He need not pose as an accomplished radiologist, nor need his decisions be final, but he adds to his own knowledge and interest and to the satisfaction of the radiologist if the two compare notes. We happen to belong to that school whose members still believe that inspection, ausculation and palpation should be part of diagnosis, but we know few conditions in which we are as willing to ask for technical and instrumental aid as in pulmonary tuberculosis. It must be recognized that diagnosis can often be made in pulmonary lesions before physical signs or symptoms occur.

Serial films provide an accurate method for following the course of pulmonary tuberculosis and are invaluable aids in determining the prognosis; and stereo-roentgenograms should be made.

It is not within the province of this paper to give detailed descriptions of the roentgenologic aspects of the various tuberculous lesions. It may be noted, however, that it is insufficient to state that "the patient has a childhood or juvenile type of tuberculosis." Whether the involvement is parenchymal or mediastinal or both should be determined, as well as whether the parenchymal lesions are localized or disseminated. The location, extent, intensity and evenness of consolidation, and the presence of cavities in the parenchymal lesions should be noted. Disseminated lesions are mainly of two types: the bronchial-distributed caseous-bronchopneumonia and the blood-borne miliary tuberculosis. They are usually distinguishable on the roentgenogram. Hilus shadows should not be designated merely according to their size, but particular mention should be made of the degree of calcification.

There are no exact roentgenologic criteria for the designation of a given lesion as tuberculous. Perhaps of all signs, calcification is the most significant. In the absence of calcification, different degrees of density and patchy distribution are strongly suggestive. When such a lesion persists for an extended period the chances that it is tuberculous are much increased.

Varied views are held in regard to the diagnostic value of the tuberculin test. It has acquired some disrepute as the result of an attempt to attach to it unwarranted diagnostic or immunologic significance. Usually a negative reaction excludes the presence of tuberculosis especially if it is still negative on a second trial with increased dosage, and provided known active material is employed. In advanced or terminal stages of

FIGURE 5

Tuberculin Test During Acute and Convalescent Stages of Diseases in the Same Patients (Eddy and Mitchell) (Am. J. Dis. Child. 1930, *40*, 771)

Disease	Number of Cases	Febrile Stage		Convales. Stage	
		Number Positive	Per Cent Positive	Number Positive	Per Cent Positive
Measles	200	7	3.5	30	15.0
Diphtheria	105	13	12.0	21	20.0
Poliomyelitis	38	3	8.0	4	10.5
Scarlet Fever	435	17	4.0	84	19.0
Varicella	52	4	8.0	12	23.0
Pertussis	72	3	4.0	3	4.0
Miscellaneous	32	2	6.0	5	16.0
Total	934	49	5.0	159	17.0

tuberculosis the test may be negative and it may be inhibited, too, as our own studies (Fig. 5) have shown, by such nonspecific conditions as severe inanition, dehydration, or by any severe febrile disease such as measles, scarlet fever, grippe, pneumonia, pertussis, typhoid fever or meningitis.

A positive reaction indicates that the patient has tuberculous infection and is sensitive, that is, allergic to the tuberculin protein. Once positive, the test almost invariably remains so but it is possible for such perfect anatomic healing or such complete fibrosis of the infected area to take place that sensitivity ceases. The test then becomes negative. Such instances have been reported. Although it has been claimed that the intensity of the reaction or the amount of tuberculin necessary to produce it has prognostic value, this is certainly not our own experience. It does not seem that a strong tuberculin reaction can be correlated to high immunity or the reverse.

Obviously a positive reaction in infancy has a more serious import than in later childhood but any time before puberty it indicates the necessity for careful study and close observation and suggests that any symptoms not otherwise explicable may be tuberculous in nature.

Of the various means of performing the tuberculin test, the Mantoux or intracutaneous method has proved to be the most sensitive and permits the use of graduated doses.

At the present time efforts are being made to develop a more sensitive tuberculin which will not be so apt to produce severe reactions and can also be more accurately measured. The so-called M.A. 100 tuberculin protein seems to be an advance in this direction.

Recently emphasis has been placed upon the examination of the white blood cells. By means of a supravital staining technique the number of monocytes and lymphocytes are determined. Their ratio to one another is presumably indicative of the activity of the disease. The monocytes are increased during stages of activity and the lymphocytes decreased, the converse being true during the stage of healing.

There is one laboratory aid which is a *sine qua non* for the certified diagnosis of tuberculosis, i.e., the isolation of tubercle bacilli. From older children sputum may be obtained as readily as from adults. Infants and younger children are prone to swallow sputum and it is frequently difficult to obtain a specimen for examination. There are several methods which justify a trial if sputum cannot be obtained directly, such as producing a cough reflex by the insertion into the nasopharynx of a gauze or cotton pledget attached to an applicator or tongue blade, stool examination, and examination of the gastric contents.

In the hands of such competent investigators as Armand Delille, Poulsen and Schick, gastric lavage has proved to be a highly satisfactory means for finding the tubercle bacilli. If the



Fig. 6. Roentgenogram taken at the time of hospital admission. Shows consolidative lesions of left upper lobe and diffuse lesions of right upper.

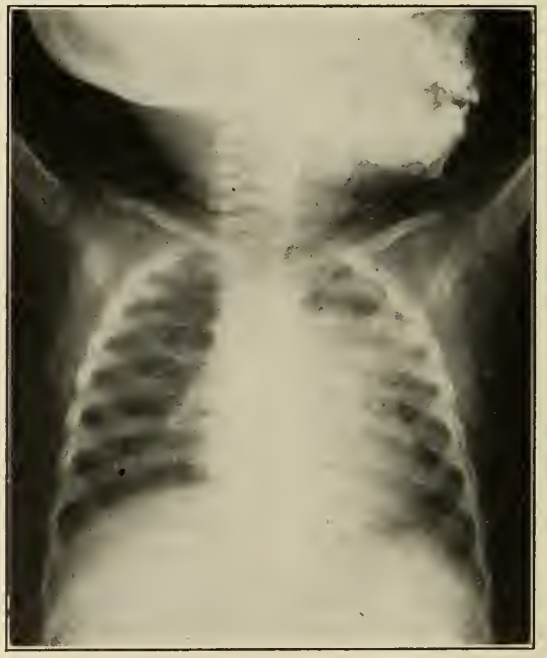


Fig. 7. Roentgenogram taken 7 months later. Shows beginning clearing.

bacillus is not found on direct smear, guinea pig inoculation and culture upon artificial media should be resorted to. The importance of these methods is emphasized by the recent work of Opitz. He has isolated tubercle bacilli from the sputum or stomach washings of patients with perifocal pulmonary lesions, with tracheobronchial adenitis, with extra-pulmonary tuberculosis when the lungs were apparently intact, and in cases of tuberculous meningitis. If these findings are correct it will be necessary to change radically our present conception of what constitutes the so-called "open" tuberculosis.

Such in general is the examination of the child

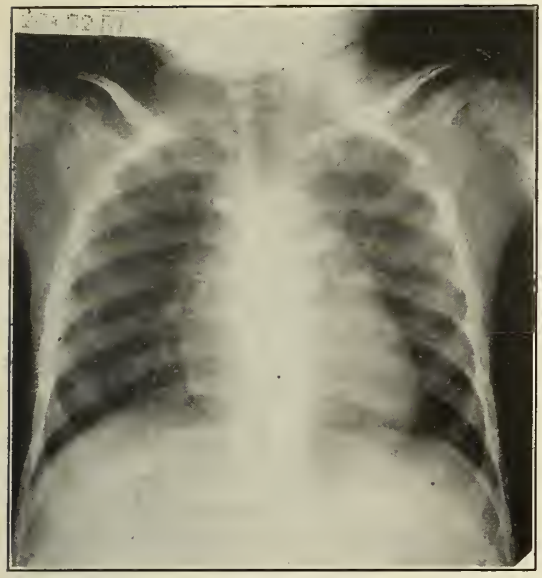


Fig. 8. Roentgenogram taken 4 years later. Shows calcification in the area of the left upper as well as in the right hilus region.

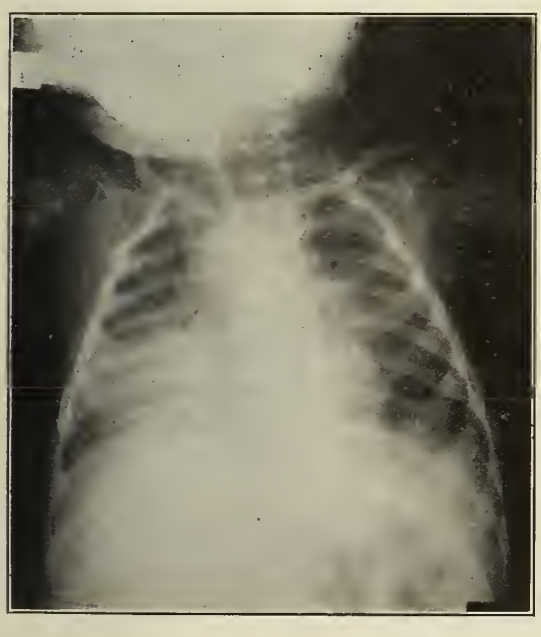


Fig. 9. Roentgenogram taken on 8-13-31 shows lesion in right lower.

suspected of having tuberculosis. We are aware that it is one thing to outline the procedures to be followed and quite another to make the diagnosis from the available data. Continued experience has made us rely more and more on the tuberculin test as a detector of tuberculous infection and on roentgenologic and bacteriologic examinations for the determination of active tuberculous disease. Careful history taking and physical examination, although not to be neglected, must take a secondary place.

Tuberculosis mortality is probably declining, although there are difficulties in determining actual comparative figures. Greater interest and knowledge always leads to an apparent increase of a disease through an increased search for it by better means, and this is certainly true of tuberculosis. In Europe the distress of war times and their aftermath increased the incidence and death rate. Even in the United States, if the figures may be accepted, there is not so great a decrease in mortality from tuberculosis in children as in adults. Is there such a thing as a gradually increasing racial immunity to tuberculosis? This probably occurs with other diseases. Apparently syphilis is a less virulent disease than formerly, even when improved treatment is taken into account. Statisticians can demonstrate that the death rate from diphtheria was declining before the use of antitoxin. In many localities scarlet fever is a decidedly milder disease than formerly. The experience in the Faroe Islands in which the mortality from measles was very great, when it attacked a group of people previously free from it for generations, argues for an inherited immunity of a sort. So, too, the fact already cited that the tuberculosis death rate is high in primitive peoples whose ancestors have not for generations had the disease may have significance. We can believe, then, that those who have been able to survive tuberculous disease may pass on a resistance even though we cannot actually prove such a phenomenon.

Age is a great factor in prognosis. It was not so long ago that there was a general impression that tuberculosis acquired in the first year of life was almost necessarily fatal; in the second year largely fatal, and that the prognosis improved as the age at which it was acquired increased. This last is quite true but the attitude toward tuberculosis even when it is acquired in very early life is much more optimistic than formerly. Older figures were based upon a comparison of mortality with clinically recognizable lesions. A pulmonary lesion which is unmistakably and readily diagnosed by physical examination is reasonably far advanced and the liability of death in a child under these conditions is great. Today recognition of pulmonary lesions by roentgenograms before they can be diagnosed by physical examination has taught us that not a few infants with tuberculosis recover.

Why then do certain children die from tuberculosis if it is true that most infections tend to be self-limited? The age at the time of the initial infection, the sex, the state of health, the virulence of the organism, the size of the infecting dose, the type of the consequent lesion and its location, repeated infections, early diagnosis and treatment all contribute to the ultimate outcome.

FAVORABLE OUTCOME OF TUBERCULOUS DISEASE IN INFANTS UNDER ONE YEAR OF AGE

E. D: Colored boy admitted to the hospital March, 1928, at the age of 7 months. Ap-

peared to be in good health except for moderate rickets. The consolidation of the left upper lobe was suspected from physical examination and this with changes in the right upper is shown on the roentgenogram. Shortly after admission he had a rather stormy course during which time he had a purulent otitis media. The subsequent course was uneventful except for rather frequent attacks of rhinitis and the weight curve for the 14 months showed a very adequate increase. The patient appeared to be well in spite of *X*-ray findings. (Figs. 6, 7 and 8).

G. F.: White male 6 months of age. Admitted to hospital April, 1931, with tentative diagnosis of enlarged thymus. Roentgenogram of chest revealed infiltrative lesion in right lower lobe. Measles May, 1931; persistent fever June, 1931; sputum positive at this time. Since August, 1931, course has been relatively uneventful and patient is now at Preventorium in good physical condition. (Fig. 9.)

Such favorable outcome as just demonstrated is by no means the invariable rule.

If infection with tuberculosis could be controlled, the optimum time for it would be after the age of five years and before puberty, and only after the child had had measles and pertussis. Mortality is highest during the ages of infancy and puberty, particularly in the latter instance among adolescent girls.

Other factors being equal, a child in good nutritional condition is better able to cope with a tuberculous infection than is a malnourished one. That different strains of tubercle bacilli vary in the degree of their virulence is probable and the quantitative factor has been demonstrated experimentally. The type, extent and location of the lesion are of utmost importance. Prognosis is good in cases of focal pulmonary infections with minimal tracheobronchial lymph-node involvement. Demonstrable parenchymal lesions have a much graver prognosis. Progression of a lesion as shown by serial roentgenograms, cavitation, the development of new lesions and such symptoms as persistent fever, rapid pulse, hemorrhage and loss of weight are unfavorable signs. Miliary tuberculosis with or without meningeal involvement is almost invariably fatal. The secondary lesions of the adult apical type which are not infrequently seen in adolescent children should be regarded seriously, and particularly is this true in girls.

However, not all extensive parenchymal lesions terminate unfavorably. The evenly consolidated lesions which have been previously described as epituberculosis or nonspecific infiltration usually run a benign course. But of even greater importance is the growing list of recoveries from progressive infiltrative lesions. Such instances are creating ever-increasing evidence against the making of unqualified grave prognoses and while they do not occur in sufficient numbers to permit of too great optimism, they do permit a considerable degree of hope.

TREATMENT OF SYPHILIS

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THE problem of syphilis is one that confronts every practitioner of medicine. It has been estimated that from 15 to 20 per cent of the chronic invalids in American hospitals are there because of the effects of syphilis. No organ or tissue of the body is immune to the invasion of the spirocheta pallida and the problem of therapy touches the daily practice of every physician. More than 200,000 cases of syphilis are reported each year to the public health authorities in the United States, and this number probably represents only a fourth or fifth of the number of cases actually under medical care. The therapy of syphilis is thus a subject of vital importance, and time spent in discussion of this subject is time well spent by the members of the medical profession. A great variety of treatment systems have been proposed for this disease and the literature is replete with the recorded experience of students of syphilis from which one may crystallize certain principles essential to its management.

The physician of today who is called upon to treat syphilis in any of its stages may regard himself as most fortunate in comparison with the practitioner in the first decade of this century. Beginning with the researches of Ehrlich there have been innumerable weapons added to our therapeutic armamentarium. The following table illustrates the anti-syphilitic drugs available to the doctor of 25 years ago and those available today:

THE THERAPY OF SYPHILIS

In 1908	In 1933
	ARSENOBENZENES
	Arsphenamine
	Neoarsphenamine
	Sulpharsphenamine
	Acetarsone (Stovarsol; Spirocid)
	Tryparsamide
	BISMUTH
MERCURY	MERCURY
IODIDES	IODIDES
	FEVER THERAPY

There has been a considerable difference of opinion among syphilologists as to the best method

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of employing these newer remedies. Upon Ehrlich's shoulders has fallen the blame for creating a misconception of the value of arsphenamine when in his enthusiasm over "therapia magna sterilizans" he implanted the belief in the minds of the medical profession at the time of the introduction of his revolutionizing drug that this drug in one or a few doses would destroy every spirochete in the syphilized individual. Unfortunately for his theory, complete annihilation of the spirochetes does not occur with one or even many doses of an arsenobenzene, and his brain child was the subject of much criticism by many of those who used this remedy early in its career and then observed the inevitable recidives that resulted, not as a direct result of the arsenical therapy but as a result of too little therapy.

We now know that the time limits for the treatment of syphilis have not been shortened by the newer drugs, and that treatment is not a matter of a few weeks or months but is still to be reckoned by years.

This is the sentence we must pronounce when the evidence convicts a patient of being a syphilitic. It is best to explain to the syphilitic patient at the very start that he is faced with long-continued treatment. The economic aspect of the treatment of syphilis is of great importance to the affected individual and is undoubtedly one of the reasons why treatment is so often prematurely stopped. There is no excuse for charging excessive fees for treating syphilis for the cost of drugs is relatively low today. Explanation of the course and future possibilities of the neglected infection will usually prevent the tendency of patients to stop therapy when they see the visible manifestations disappear or know that their blood Wassermann is negative.

Arriving at the point of determining the best therapeutic method to use in the treatment of a given case of syphilis, the practitioner of medicine is confronted with a variety of systems and may be at a loss to know which method will give the best result. As a matter of fact, agreement upon the major principles of therapy is probably of greater importance than agreement upon a certain combination of drugs. Attempts to standardize the treatment of syphilis have failed thus far. It might be possible to standardize the treatment of early syphilis, but at the present time standardization of the treatment of late syphilis would be inadvisable, for each case requires special consideration. For the purpose of convenience and better discussion, I will consider the question of treatment under the headings early syphilis, asymptomatic or latent syphilis, late syphilis, and congenital syphilis.

TREATMENT OF EARLY SYPHILIS

The first course of treatment commonly spells the fate of the patient, for the thoroughness or the inadequacy of this treatment has an enormous influence upon the subsequent course of the malady; indeed the future eradication of syphilis as an epidemic disease depends largely upon the solution of the problem of efficient and sufficient early treatment. For this reason an adequate knowledge and understanding of the treatment of early syphilis on the part of the medical profession is of far-reaching importance. Properly treated the patient with primary or secondary syphilis has an excellent chance of escaping the disastrous end results of the disease. If all cases could be properly managed from the time of the earliest manifestations it would not require many years to eradicate syphilis from the face of the earth. In fact, since the introduction of the more modern and more efficient methods of treatment, syphilis is already losing its foothold, particularly in certain countries of Europe.

In Great Britain Col. Harrison has presented facts showing a reduction in cases of syphilis from 40,000 in 1920 to 28,000 in 1928. In Germany the census method of determining prevalence has shown a significant decline in consecutive years which in a typical area amounted to 31 per cent between 1921 and 1927. In Denmark there has been a progressive decline in syphilis of more than 50 per cent since 1921 (quoted by Parran, *J. A. M. A.*, 1931, 97, 74). Parran states that in the United States the reports are less favorable; there are constantly under treatment in this country nearly half a million persons suffering from syphilis. About one-third of these are cases of early syphilis.

I have stated that numerous plans of treatment have been devised and advised. Perhaps the most complete plan devised in the United States is that chosen by a Government appointed committee, consisting of Doctors Moore, Cole, Solomon, Wile, Stokes and Schamberg. This plan calls for continuous therapy, alternating an arsenobenzene (either arsphenamine or neo-arsphenamine) and bismuth in courses of each for a minimum of 70 weeks.

The method which I have used for the past several years is the conjoint use of neo-arsphenamine intravenously and bismuth intramuscularly, with alternate but briefer courses of mercury or bismarsen (bismuth arsphenamine sulphonate). This method appears to have numerous advantages. First, it permits the use of smaller doses of each of these drugs and thus lessens the danger of toxic effects from either one. A maximum dose of 0.6 grams of neo-arsphenamine is recommended as compared with a generally used maximum dose of 0.9 grams, and usually a dose of 100 mg. of bismuth is used intramuscularly as compared with a maximum dose of 200 mg., thus lessening the local pain and possible toxic effects of this drug. Secondly, this combination of drugs gives us a more continuous action on the spirochetes. We know that arsphenamine or neo-arsphenamine administered intravenously are rapidly absorbed, but are also rapidly excreted within

24 to 48 hours. During this period of time the effect of either is telling but by no means suffices to destroy all of the spirochetes, and before the next dose (which in most clinics is at an interval of five to seven days) there is an opportunity for the organisms to retrench and multiply; whereas if bismuth is used simultaneously the curve of bismuth absorption is on the upward trend until saturation is reached and then continues at a level, so that there is continuous instead of intermittent bombardment of the infection. Furthermore, if the patient disappears from the physician's care (and many of them do and cannot be brought back) bismuth continues to be absorbed from the depots in the muscles and there is a prolonged spirocheticidal effect, thus lessening the danger of recidive.

The question has been raised as to what constitutes the ideal time to begin therapy in a case of early syphilis. A few syphilologists, and among them Dr. William Allen Pusey, have held the view that it is better to wait for the end of the secondary period before beginning therapy in order that the natural immunity of the body to the disease may be fully developed. There are several reasons for not accepting this point of view. In the first place, the patient is permitted to go about untreated during the very time when he or she is most likely to disseminate the disease. This is against all principles of preventive medicine and public health. Secondly, it is reasonable to believe that the earlier the patient is treated. the better the opportunity for complete arrest or cure of the disease, for each day that elapses between infection and treatment the spirochete becomes more disseminated and has an opportunity to throw up the intrenchments which make it more difficult for the drugs to reach it.

In brief, the treatment of a case of early syphilis by the method advocated would be as follows: The first day the patient is given an intramuscular injection of 100 mg. of potassium bismuth tartrate (or any other reliable bismuth which the physician may select). This will begin the assault upon the spirochetes, but will not cause such tremendous destruction of these organisms that a toxic reaction will result. Furthermore, this will lessen the liability of a Herxheimer reaction. In 24 hours the patient is given an initial injection of 3 decigrams of neoarsphenamine intravenously. Arsphenamine may be used instead of neoarsphenamine if desired, but although more therapeutically active it has the disadvantages of being much more difficult of administration and more liable to give rise to toxic symptoms. For the next twelve weeks both an injection of bismuth and of neoarsphenamine is given weekly, either spacing the two drugs by three or four day intervals, or both may be administered on the same day. The dosage of neoarsphenamine is raised the second week to 0.45 grams and the third week to 0.6 grams. After the twelfth week either mercury given by inunction or injection, or bismarsen (bismuth arsphenamine sulphonate) given intramuscularly may be substituted and continued for eight weeks. Wassermann tests may be made at any intervals desired but only for the guidance of the physician. The course of combined bismuth and neoarsphenamine is now repeated or if treatment was started before the Wassermann became positive it may suffice to continue therapy from this point on by alternate bismuth and mercury therapy. Treatment the first year and for at least one-half of the second year should be continuous. Thereafter it is a matter of judgment after taking all clinical and laboratory findings into consideration. A spinal fluid examination is desirable some time during the first year, and if positive, may call for a reconsideration of the therapeutic plan. A third year of observation is desirable for the patient who is apparently cured of his infection during the first or second year, and in the case of females an even longer course of observation is desirable.

The value of a therapeutic regime can only be determined by a study of results. In 1927 I published a study, in a large series of cases, of the effect of bismuth alone and in combination with the arsenobenzenes upon the Wassermann reaction (*Amer. Jour. of Med. Science*, 1927, 173, 237), and in this series were fourteen cases of secondary syphilis treated at the Graduate Hospital by this method. It was found in this small series that an average of six weeks' treatment sufficed to render the Wassermann negative. In 1931, Rhodes (*Jour. of the Indiana State Med. Asso.*, 1931, 24, 606) reported on twenty-three additional cases of secondary syphilis treated in Dr. Schamberg's clinic by this method. Of twelve patients who attended regularly, eight showed a reversal of the serological reactions in from five to eleven weeks, two became negative during a subsequent course of bismuth therapy, and two were still positive. Of eleven patients who attended irregularly eight were Wassermann negative after an average of eight weeks of combined therapy, one became Wassermann negative during a subsequent course of bismuth therapy, and two lapsed treatment after the first course of twelve weeks, with their Wassermann's still positive.

A review of the literature finds others now using this method of combined therapy. Richon and Bocage (*Vie Medical*, 1930, 11, 105) report that in Ravaut's clinic combined bismuth and arsenobenzene therapy has given better results than alternate courses of the two drugs. Renald (*ibid.* 1927, 8, 374) claims that with the combined bismuth and arsenobenzene therapy an average of six weeks' treatment suffices to render the Wassermann negative in early syphilis. In England, Harrison is using this method and, in a personal communication to Dr. Schamberg, champions the method. The safety of using these drugs simultaneously is attested by the report of Beintema (also by letter) that in his clinic at the University of Groningue he has seen no reactions or accidents after 996 combined simultaneous injections in a series of 96 patients.

TREATMENT OF ASYMPTOMATIC (LATENT) SYPHILIS

After the subsidence of the symptoms of secondary syphilis, we know that the patient goes into an asymptomatic period. The absence of

signs and symptoms may be the result of treatment received or may occur spontaneously as the result of specific antibodies in the system. This period is often called the latent stage, but the term asymptomatic is better for latency implies slumbering or inactivity, whereas insidious inflammatory and degenerative changes may be going on without producing obvious or discoverable symptoms. Usually the only evidence of syphilis at this stage is the Wassermann reaction.

Treatment must be continued at this time just as if symptoms were present, and furthermore independent of the outcome of the Wassermann test. It must be remembered that a negative Wassermann reaction does not exclude the presence of living spirochetes in the body. Every patient should secure an irreducible minimum of treatment which is based upon the sum total of medical experience.

To cease treatment in this stage because the patient is free of symptoms and has a negative Wassermann reaction is to invite disaster, for the vast majority of cases will relapse clinically or serologically at some time in the future.

There is also the period of so-called *late* latency which may persist for 10, 20, 30, or more years. This stage may represent complete arrest of the syphilitic process, or it may be only a period when pathologic activity is going on in hidden recesses of the body, particularly the cardio-vascular or nervous system.

How actively should we treat these cases of early or late asymptomatic syphilis? Here each individual case must be decided according to the age of the infection and amount of past therapy, and no set rules of therapy can be outlined. I would call attention to the value of intramusclar therapy in asymptomatic syphilis.

TREATMENT OF LATE SYPHILIS (TERTIARY SYPHILIS)

The treatment of late or tertiary syphilis differs essentially from that of early syphilis, for the aim and object are not the same. In early syphilis the therapeutic goal is the extermination of all of the invading spirochetes in the body with as vigorous an effort as is consistent with safety to the patient. In late syphilis, the purpose of treatment is to effect a removal of the presenting symptoms, to prevent their return and to keep the patient in good health for as many years as possible.

The question of effecting a radical cure in late syphilis is not one that demands immediate attention. The patient having had for a number of years a syphilitic infection with inadequate or no treatment, in all probability has lesions which interfere with the structural integrity of his organs. The chances of eradicating the disease after long years of residence of the spirochete in the tissues are not at all favorable. Vigorous treatment with the idea of bringing about a radical cure is ill-advised and prone to do harm. Many patients have had their lives shortened by too zealous an effort on the part of the physician to overcome the disease. Furthermore, in persons over fifty years of age, one should not make too vigorous an attempt to reverse a positive Wassermann reaction. The patient's expectancy of life may be as good with a positive as with a negative Wassermann.

Treatment should be of a conservative character, all of the remedies used being such in dosage as will not tend to induce reactions. One should never use large doses of an arsenobenzene; in fact it is usually better to forego the arsenobenzenes and use bismuth or mercury in conjunction with the iodides. Late syphilis involving the skin only will call for a different type of therapy than late syphilis of the viscera, just as late syphilis of the viscera requires treatment quite different from late syphilis of the nervous system.

TREATMENT OF VISCERAL SYPHILIS

There is perhaps no field of organic disease in which a prognosis is more difficult than in certain types of visceral syphilis. This applies particularly to hepatic and cardiovascular syphilis. The greatest care is necessary in treating syphilis of the liver or cardiovascular system to prevent the treatment from doing more harm than good. The precepts for therapy of the syphilitic liver and heart laid down by Wile in 1922 (*Amer. Jour. Med. Science*, 1922, 164, 415) are still as valuable today as they were eleven years ago. There are certain mechanical factors in syphilis involving these two organs which are of vital importance in the treatment and which affect the prognosis in a given case. The end-result of all syphilitic processes is a fibrosis. This fibrosis is materially hastened by energetic and intensive treatment. The process of repair in a parenchymatous organ in which fibrosis is going on depends upon its ability to recuperate by hypertrophy or by reproduction of its substance. The latter two functions are distinctly slow processes. Treatment inevitably produces a scar and should be of the type which leads to a slow rather than a rapid process of repair. Thus too rapid shrinking of an enlarged liver (hepar lobatum or gummous hepatitis) may result in a rapid shrinking of the liver with the result that the portal circulation is cut off and a persistent ascites develops. Milder therapy results in a more gradual healing and shrinkage in the liver, permitting the gradual development of a collateral circulation.

Clinical syphilis of the heart resolves itself into a consideration of the symptoms dependent upon myocarditis, aortic regurgitation, aortic aneurysm, syphilitic aortitis and coronary disease. As Harlow Brooks pointed out twenty years ago, the treatment of the syphilitic heart resolves itself into two factors: the syphilitic infection on the one hand, and the cardiac defect on the other. Personally, I would not feel qualified to discuss the cardiac defects, and would seek the aid of the internist in determining the extent of such defects, but as a syphilologist I follow the precepts

of therapy as outlined by my former teacher, Dr. Udo Wile, and avoid intensive treatment. Remarkable improvement may follow intensive treatment of these cases with the organic arsenicals, but this is followed in some cases by rapid deterioration, with evidence of accentuation of the original cardiac defect. Thus we have the paradox of the patient getting better or well of his syphilis, and dying as a result of his cardiac lesion.

Thus it is seen why we should insist upon thorough examination of every case of late syphilis that we may not overlook some serious visceral lesion and thus err in our therapeutic procedure. We avoid the organic arsenicals because of their rapid action, and prefer to institute treatment with mercury and iodides or perhaps bismuth intramuscularly, and only employ the arsenicals after prolonged treatment has been given with the milder drugs. Persistence in treatment, however, should be the rule, for visceral syphilis may be said to be never cured.

TREATMENT OF NEUROSYPHILIS

As a preliminary to a brief discussion of the treatment of neurosyphilis, I would like to emphasize the importance of routine spinal fluid examination. The U. S. Government appointed committee determined that an examination should be made at about the sixth month of the infection. In the syphilis clinic at Temple Medical School we are now obtaining spinal fluid via the cisternal route, which has the great advantage of resulting in no post-puncture symptoms and thus not requiring hospitalization. In a survey of the literature on the results of this method of obtaining spinal fluid, I have been unable to find more than two instances of death, and both of these were in patients who were subsequently shown to have brain tumors.

Here again as in the case of visceral syphilis, I feel that the finer points in diagnosis should be left to the trained specialist, and that cooperation between the syphilologist and neurologist is desirable. The development of fever therapy and tryparsamide has reached a point that revision of the older conceptions of the prognosis of neurosyphilis and particularly paresis must be revised. Spinal therapy such as the Swift-Ellis treatment is seldom used at the present time, whereas a few years ago it was considered as the only hopeful method of treating syphilis of the nervous system.

I am more and more convinced of the great value of malarial therapy, in reviewing cases which were treated by Dr. Schamberg and myself some years ago. I have recently seen two of our private patients who eight years ago presented the evidence in the spinal fluid of early paresis, with typical paretic curves and strongly positive spinal fluid Wassermann reactions, and today they are entirely asymptomatic and serologically free of the disease. Both have since married; their wives have given birth to healthy children. Of course, we know that failure attends other cases. Our attempts to replace malarial therapy by other fever-producing methods, the most recent of which is endothermy fever, have thus far not given promising results, although the time is too short for dogmatic statements.

The value of bismuth in the treatment of neurosyphilis must not be underestimated. The continuous bombardment of the disease which results from the continuous absorption of this drug from intramuscular depots is a valuable adjunct to other therapeutic procedures, and the recent development of iodobismitol by Mehrtens and his associates promises us a form of bismuth that will penetrate into the spinal fluid and brain.

CONGENITAL SYPHILIS

The question of the treatment of congenital syphilis is of special interest to me as for the past ten years I have conducted a clinic for fifty to sixty children weekly at the Graduate Hospital. I am still undecided whether intensive or mild, intermittent therapy gives the best results. I believe that chilldren with congenital syphilis should be kept under surveillance for many years, but the problem of treatment is an individual one and rules cannot be laid down to cover this group as a whole. I have outlined the following general rules of therapy for use in the congenital syphilis clinic at the Graduate Hospital.

1. *Syphilis of the New Born*—(a) Weekly injections of sulpharsphenamine, dose 0.01 gram per kilo of body weight, dissolved in 1 cc. of distilled water and injected intramuscularly; (b) mercury in the form of the official Ung. hydrargyria 0.05 gram spread on the skin, covered with lint and bandaged; (c) substitution of bismuth after the child is two months old, giving a series of twelve to sixteen injections; (d) subsequently alternate courses of sulpharsphenamine and bismuth for the first two years.

2. *Early Congenital Syphilis*—Treatment as above with increase in the amount of mercury used as an inunction and the substitution of neoarsphenamine intravenously for sulpharsphenamine should the latter prove too painful.

3. *Tardive Congenital Syphilis*—(a) An initial course of twelve to sixteen injections of bismuth intramuscularly. Dosage from ¼ gr to 1 gr., depending upon the age and weight; (b) following the course of bismuth, a course of from eight to twelve injections of either neoarsphenamine or sulpharsphenamine; (c) a second course of bismuth, or if the child is in conscientious hands, a course of forty mercurial rubs may be given, followed in turn with a course of twelve to sixteen injections of bismuth; (d) after this a second series of arsenobenzene injections may be given, preferably using the one which was not used in the first course; (e) iodides when required, but

not routinely; (f) treatment continuous for the first year, almost as rigid the second year, and after that two courses of treatment a year, preferably using either intramuscular injections of bismuth or mercurial inunctions.

THE PRACTICAL MANAGEMENT OF SYPHILIS

I have thus far attempted to discuss briefly the various aspects of the treatment of syphilis, as applied to the various stages of the disease. In spite of the fact that there may be difference of opinion in material of detail in discussion of the therapy of syphilis, I feel that there should be agreement in the major principles. I would lay down the following statements in the form of propositions:

1. It is not so much the particular selection of this or that antisyphilitic drug which spells success in treatment, but rather the systematic and persevering treatment over a period of years with any of the approved remedies.

2. Any of the arsphenamines used with a heavy metal over an adequate period of time will control syphilis in the vast majority of cases.

3. The concurrent use of one of the arsphenamines and bismuth constitutes an excellent method of treatment for early syphilis, both from the standpoint of therapeutic results and absence of toxic effects.

4. Continuous treatment is superior to intermittent treatment.

5. Every patient with syphilis must receive an irreducible minimum of treatment, irrespective of the presence or absence of symptoms and of the outcome of the serologic tests.

6. In primary and secondary syphilis the patient should receive as vigorous treatment as is consistent with his safety.

7. In late syphilis, treatment must be based upon a consideration of each case. Thus for mechanical reasons hepatic and cardio-vascular syphilis call for mild but persistent therapy; neurosyphilis calls for the use of specialized therapeutic procedures.

THE DEFECTIVE DELINQUENT; A REVIEW OF 514 CASES

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THE determination of the cause, and the prevention and correction of crime is probably the most important social problem facing our governments at the present time. It is our purpose to present the essential facts from a study of 514 defective delinquent patients admitted to the Institution for Feebleminded at Orient, to discuss briefly the difficulties we have encountered in the training and management of these patients, and to point out the defects in our present plan of treatment.

A defective delinquent is that individual who displays persistent delinquent or criminal tendencies and who, upon examination, shows a lack of responsibility for his actions by reason of mental deficiency. According to the British definition, a feebleminded person of the moron level, with whom we are chiefly concerned, is one who, by reason of defective or arrested cerebral development, existing from birth or from an early age, is incapable at maturity, of competing with his normal fellows or of managing himself or his affairs with ordinary prudence, except under favorable conditions or under careful supervision and guidance.

In recent years, there has been some disagreement as to the line of demarcation between a normal and a defective individual by the usual standardized methods of measuring intelligence. Without entering into the controversial phases of this question, we have, for the purposes of this discussion, arbitrarily drawn the line at a mental age at maturity of 12 years, or at an intelligence quotient of 75, by the Stanford revision of the Simon-Binet method. The borderline group has never been clearly defined, but we feel that it begins in the neighborhood of 9 years, 7 months, or at an intelligence quotient of 60, on the basis of 16 years as the average age of intellectual maturity. We realize fully that the intelligence quotient is not a safe guide in the diagnosis of mental deficiency, as there are many men and women whose intelligence quotients are below 75 who are making successful adjustments of their lives, according to the social standard set by the British definition. It is for this reason that we have placed the borderline group at such a low level, reserving the right to change these levels in the light of future investigations.

INCIDENCE

In our experience, only 11.2 per cent of 4586 mentally defective patients have shown delinquent or criminal tendencies. The vast majority of our feebleminded patients, in contrast to the de-

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linquent group, are docile, well-behaved, industrious, affectionate, and present no great obstacle to training and discipline under the favorable conditions of institutional life.

ETIOLOGICAL FACTORS

The chief factors concerned in the cause of the mental defects in our cases are, viz., (1) defective heredity and (2) disease or injury in early infancy or childhood. About 46 per cent of our patients present evidences of mental deficiency in their family histories; if psychoses and epilepsy are also considered, the proportion is only raised to 50 per cent. Apparently psychoses and epilepsy play little part in the hereditary stock of these cases. However, there is little doubt that a defective heredity is the most important discoverable cause of mental deficiency, although its importance has been over-estimated in the past.

Next to heredity, cerebral injury or disease, either at birth or in the early years of life, is undoubtedly of considerable importance. Such conditions were discovered in the histories of 16 per cent of our patients. The most important of these conditions are cerebral birth injuries, or head injuries incurred at an early age. Encephalitis, anterior poliomyelitis, meningitis and epilepsy occur next in the order named. There were also 22 cases of convulsions in infancy of an unexplained origin. If these instances are considered as a possible cause of cerebral trauma, the proportion of cases in this group is increased to 20 per cent.

The deleterious effect of tuberculosis, alcoholism and syphilis upon the parental germ plasm has long been advanced as a possible cause of mental deficiency in the offspring. At present, however, tuberculosis and alcoholism are considered only as contributory factors, as many authorities admit that they have never seen a case that could be attributed to either of these conditions alone. This position is well illustrated by our cases. Tuberculosis occurred in the parents in only 5 per cent, and in all except four of these, other more important factors were found. The same is true of alcoholism; while alcoholism occurred in the parents in 22 per cent of our cases, it occurred as the sole factor in only 6 per cent.

Syphilis is undoubtedly a minor factor in mental deficiency, either by its deleterious effect upon the germ plasm or by direct invasion of the central nervous system. Recent reports, however, indicate that it is not as important as formerly believed. In our own cases, the mental defect can be attributed to congenital syphilis in only five instances, or less than 1 per cent.

SOCIAL FACTORS

The mentally defective individual, because of his limited ability, poor judgment, and his peculiar susceptibility to evil influences, is much more liable to fall into delinquent tendencies than a normal person, especially in an unfavorable environment. This can be readily shown from a study of our case. Nearly 25 per cent are either foreign born, or represent the first American generation of parents born in foreign countries. An additional 25 per cent were negroes. The majority of the foreign born element come from Cleveland while the majority of colored patients come from Cincinnati, largely from a congested and crowded district, where vice, immorality, and criminality are common in the neighborhood, if not in the immediate family. Of the entire series, 70 per cent came from cities having a population of 25,000 or more, and 65 per cent came from cities having a population of 100,000 or more. In 36 per cent, the parents themselves are of low mentality and obviously incapable of providing the proper home training and discipline which is so necessary for the feebleminded. In 30 per cent of the families, the home was broken, either by death of one or both parents, or by separation and divorce. In many such cases, the remaining parent must work for a living, thus practically depriving the child of all home training and supervision.

A common school education is the most essential part of a child's education, yet less than one-half of one per cent of our patients have completed the eighth grade, 3 per cent never attended school, and only 6 per cent succeeded in passing the sixth grade. Only 5 per cent have had an extended trial in a special class, largely because of behavior difficulties. The delinquent tendencies may be first manifested at any age level, even as early as the age of five, but the most dangerous period was found to be from 10 to 14 years, which corresponds roughly to the age of puberty.

NATURE OF DELINQUENT OFFENSES

The offenses of these patients fall into the usual four groups, viz., offenses of acquisition, sexual offenses, and offenses against persons and property. In the males, petty larceny is by far the most common offense, with auto theft, burglary, bicycle theft, robbery, and breaking and entering occurring next in the order named. Grand larceny, horse theft, holdup, forgery, pocket-picking and bootlegging are less common. The most common sexual offenses in the male group are attacks on little girls, immorality, sodomy and bestiality. Incest and rape or attempted rape of adult women are rare. Assault is the most common offense against persons. Only two patients have been charged with homicide, and one, each, with accessory to a murder, and an attempted murder, respectively. Five were charged with the carrying of concealed weapons. Arson is the most common offense against property; the destruction of property, other than arson, occurred only twice, and three patients attempted to wreck traction cars or railroad trains, by placing obstructions on the tracks.

In the female group, immorality is the most common offense. Prostitution and incest are not very common. Offenses of acquisition are accounted for by only 16 cases of petty larceny. Of the offenses against persons and property, assault occurred only 14 times, and arson only twice.

A few of our boys ran through the whole list of offenses, and were charged with all the crimes in the category. Others were inclined to some particular offense. For instance, 45 boys were involved in the theft of 123 automobiles, and 18 other boys stole a total of 56 bicycles. One boy in particular was interested only in Chevrolet automobiles, having been involved in the theft of 16 cars of this particular model. Another boy was known to have been involved in the theft of 18 bicycles. One boy, at the age of 13, calmly looted a fire and police station, having turned in a false fire alarm to rid the place of its occupants.

Of 103 girls charged with immorality, 50 have had a total of 70 illegitimate children. Thirteen boys and four girls are known to have had gonorrhea, and 18 boys and 13 girls are known to have had syphilis before admission. Masturbation is almost universal. Homosexual practices are very common and exceedingly difficult to control.

MENTAL CHARACTERISTICS

The average chronological age of these patients on admission is 15 for the males and 18 for the females. An analysis of our cases shows that the median mental age of the male group is nine years, with a median intelligence quotient of 59. The median mental age of the females is 10 years, 6 months, with a median intelligence quotient of 66. Only 15 per cent of the males fall below the moron level, and 14 per cent can be considered as having average mentality. In the females, 22 per cent are below the moron level in mentality, and 14 per cent are considered of average mentality.

In addition to the defects of intelligence, emotional and character defects are very common among defective delinquents. One of their most outstanding characteristics is their imperviousness to ordinary disciplinary measures. Failing to recognize the primary defect, the parents resort to all sorts of punishment, including the rod and often abuse, with no effect. Even the special schools and special classes, where their limitations are recognized, find it impossible to cope with their behavior problems, and they are soon brought into court, usually for persistent truancy, or petty thievery. But it is soon evident that arrest and probation has little deterrent effect. Thirty-nine boys, whose records are known in detail, were arrested and brought into court a total of 261 times, an average of seven arrests for each boy. One colored boy, at the age of 10, was arrested three times in 24 hours for robbery. Their persistence in the theft of automobiles and bicycles, regardless of consequences, has already been mentioned. Fully 20 per cent have spent one or more terms in State Industrial Schools with no appreciable effect upon their behavior. More than three-fourths have become habitual offenders before their admission to the institution. If the defect were recognized at the first arrest, and institutional treatment begun at once, one wonders whether the results would be improved.

At least 50 per cent present the characteristic reactions of the psychopathic personality. Such patients usually begin to show their abnormal behavior early in childhood by queer moods, stubbornness and irritability. In the school period, they show no ambition, lack of attention, rapidly changing interests, insubordination, and frequent truancy. They are disobedient, incorrigible, rebellious to supervision, and are readily susceptible to evil suggestions. Because of their limited capabilities, they can gain little satisfaction or admiration in the school room; in compensation, they turn to truancy, lying, thievery, and other anti-social activities. In industry, they are usually complete failures. By the same limited capabilities, lack of sustained ambition and poor judgment, they soon become dependents, loafers and pool room habitues, with no respect for their social obligations.

In the institution, they are likewise rebellious, quarrelsome, extremely sensitive to real or fancied injustices, jealous and lazy. They have no sense of morals, no honor; they are persistent liars, and are quick to blame others for their own shortcomings. They feel that they are unjustly confined, resent being classed as feebleminded, and are constantly planning escape, sometimes with astonishing ingenuity. Occasionally, they will resort to violence to carry out their plans. The influence of such behavior upon the well-behaved patients of placid dispositions is sometimes demoralizing. A defective delinquent of near normal intelligence will frequently arise among his fellow patients, and banding them together, will defy all attempts at discipline. The bad influence of this insubordination soon spreads and, if not quickly checked, pervades the whole institution with a spirit of unrest and even outright rebellion, with wholesale elopements.

Probably the most difficult tendency of the defective delinquent to control, is the propensity for running away at every opportunity. Their habit of persistent truancy from home and school is carried over into their institutional life. It is difficult to teach and train them under any conditions, but under ordinary institutional conditions, it is almost impossible to hold them long enough to make the attempt. In the females, where the training is limited to housework, laundering, sewing, cooking, etc., this tendency is well controlled, but only at the price of constant vigil. In the males, however, where the training consists largely of farming, dairying, gardening and other occupations requiring outdoor super-

vision, the tendency to elope is very difficult to curb. In order to give them any training at all, certain outdoor privileges must be allowed, and it is here that most of the elopments occur. A total of 249 boys, or 64 per cent of the entire male series, have eloped a total of over 600 times. With such frequent and persistent interruptions, the futility of systematic training under ordinary institutional methods is obvious. The danger of the return of these boys to society to resume again their careers of delinquency and crime, and the expense to the state of having them apprehended and returned, can hardly be calculated.

We were able to trace only seven of our female patients out of 17 who have left the institution. Of these, two are reported to be making satisfactory adjustments, while five are persisting in their immoral practices. We were able to trace only 72 male patients who have left the institution. Of this number, 25, or 34 per cent, are reported to be making satisfactory adjustments; three are dead, one of whom was stabbed and killed in a fight; five have been committed to the Lima Hospital for the Criminal Insane. Thirty-nine, or 55 per cent, have persisted in their anti-social behavior. Of this group, 26 have been committed to correctional institutions; one is on probation, having been indicted for grand larceny; one is awaiting trial for burglary and two others are wanted by the police for burglary; the others are known to have police records, since they left the institution. These facts illustrate the ineffectiveness of regular institutional training as well as the urgent need of an effective parole system.

It is now generally recognized that the defective delinquent represents a specific type of the feebleminded. It is generally admitted that institutional methods for the training, management, and segregation of the feebleminded in general are decidedly unsuited for the defective delinquent. It is also generally admitted that the correctional measures of penal institutions are also unsuited. Superintendents of such institutions have long recognized that most of their troublesome prisoners and the majority of recidivists, who are not amenable to training and discipline, belong to this group.

In recent years the State of Ohio has taken a step forward through its Bureau of Examination and Classification of prisoners, whose object is to classify troublesome prisoners referred to it according to their physical, emotional, and mental characteristics. As yet, no definite steps have been taken for the segregation of the abnormal types. The states of New York and Massachusetts have taken a great stride toward the solution of this problem by the establishment of special institutions, the former at Napanoch, and the latter at Bridgewater. Patients are admitted to these institutions not only by transfer from other institutions, but at Napanoch, by direct commitments from the courts, and for indeterminate periods. These institutions have not only relieved the penal institutions, the mental hospitals, and the schools for feebleminded of a troublesome problem for which they were poorly equipped, but, by medical, occupational, and psychotherapeutic measures, based upon thorough examinations, they are returning many of their patients to useful lives in society, under a judicious and well regulated parole system. The fact that such patients can be retained for life, serves as a very effective deterrent on many delinquents. Other states have established separate units in connection with their regular institutions.

SUMMARY AND CONCLUSIONS

In this study, 11.2 per cent of about 4500 feebleminded patients showed delinquent or criminal tendencies, more than three-fourths of whom were habitual offenders.

Nearly half of these patients present evidences of mental deficiency in their family histories, and one-fifth present a definite history of cerebral injury, or disease of the central nervous system in early life. Parental tuberculosis, alcoholism and syphilis were found to be of little significance.

About half of the entire group were about equally divided between the colored race, and the foreign born or the first American generation of foreign born parents. Nearly three-fourths come from large urban centers, while 30 per cent come from broken homes.

Stealing or petty larceny is by far the most common offense in the males, while immorality predominates in the females. Serious offenses, such as grand larceny, homicide or rape are rare. Automobile theft is common among a certain group of male patients.

The majority of these patients belong to the moron or borderline level of intelligence.

The delinquent tendencies are usually first manifested from 10 to 14 years of age, yet the average age of admission is 15 to 18 years. It is likely that institutional results might be improved if the defect were recognized at the first arrest, and institutional management begun at once, before they become habitual offenders. In many instances, the institution is used as a last resort, after all other measures have failed.

The institution, or training school for the feebleminded, is unsuited for the care and training of this particular class, largely because of their incorrigible behavior, and their propensity for running away. These tendencies not only interfere with their training, but they have such an unfavorable effect upon the morale of the whole institution, that it interferes seriously with the care and training of the ordinary patients, who make up the largest part of the population. If this troublesome element were removed, the train-

ing of the remainder could proceed in an orderly fashion that would produce much better results.

In conclusion, we wish to stress the following:

I. The urgent need of a special institution or a separate unit of a regular institution, where, uninterrupted by elopments, these patients can be segregated effectively and given academic, occupational or vocational training commensurate with their individual needs. Farming, dairying, gardening, etc., are decidedly unsuited for this type of the feebleminded in the early stages of their training.

II. The need of an effective parole system, by means of which, selected patients who have benefited by such training, can be given a chance to adjust themselves in society under adequate supervision.

III. Patients who present histories of repeated anti-social acts, and who present the characteristics of the constitutional psychopathic personality, should not be paroled except after very careful study, and then only under the most favorable conditions. The majority of such patients should be retained for life in institutions adequately equipped to prevent their escape.

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PEPTIC ULCER OF MECKEL'S DIVERTICULUM

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A MECKEL'S diverticulum is present in something between one and two per cent of the human race. The mucous membrane of a diverticulum is usually like that of the ileum, but often shows areas that are gastric in type, and sometimes patches of duodenal, jejunal, or pancreatic type of membrane. A given diverticulum may contain two or more of these foreign types of mucosa, but the gastric predominates, being reported in at least 20 per cent, sometimes as high as 50 per cent, of specimens studied. It follows, therefore, that at least one of every five hundred persons has a Meckel's diverticulum containing gastric type of mucosa, whose acid secretion may cause peptic ulceration of the adjacent bowel wall.

Peptic ulceration of Meckel's diverticulum has only recently been recognized as a clinical entity. We are presenting two contrasting examples. In the first case we have the more typical clinical picture of recurring massive hemorrhage from the bowel without specific symptoms or physical signs; in the second the infrequent circumstance of perforation and an acute abdomen as the initial symptom of the condition.

Case I is an infant girl of fifteen months. Her mother reported that the child had been quite well, when one morning she passed a stool containing a large amount of red blood. She passed a similar stool that evening. There were no other symptoms, no apparent pain or colic, no vomiting or fever. On the morning of the second day blood was passed again, this time giving the stool a very dark red color, almost a tarry appearance. This stool was kept for examination, and I believe must have contained about two ounces of clotted blood. By this time the patient was weak and restless, but still appeared free from pain, and had not vomited. I saw her for the first time a half hour later, and found her a well nourished infant of fifteen months, exceedingly pale, but otherwise not showing signs of acute illness. The pallor was the only positive finding. The abdomen was negative.

Her history up to the age of nine months was not remarkable. But at nine months, while enjoying excellent health, she suddenly passed a stool with a large amount of blood. This left her so weak and pallid that she was sent to a hospital where she remained for eight days, and she was treated for weeks afterwards for her anemia. At eleven months she developed pneumonia, but made a good recovery. She then remained well up to the time of the present illness.

With this history, and in the absence of specific physical findings, I made a provisional diagnosis of peptic ulceration of Meckel's diverticulum, and sent her into the Good Samaritan Hospital. Her temperature was 100° rectally. Red blood count 1,550,000; haemoglobin 35 per cent; white blood count, 5,100. Bleeding time and clotting time were within normal limits. Dr. Johnston examined her at the hospital, and his examination, which included a rectal examination, was without positive findings for the pallor. The abdomen was negative; no polyps were felt.

An immediate blood transfusion, and a second transfusion six days later brought the haemoglobin up to 80 per cent. An *X*-ray series of the gastro-intestinal tract was negative. Eight days after admission a laparotomy was performed wth a pre-operative diagnosis of peptic ulcer of Meckel's diverticulum. At operation a small diverticulum resembling a chicken's heart was found on the ileum about 14 inches above the cecum. Externally it appeared normal and it was excised with a narrow cuff of intestinal wall. An appendectomy was also done. Examination of the diverticulum revealed that the ulcer was located at the junction of gastric and ileac mucous membranes. The entire mucous membrane of the diverticulum was of gastric character, that in the proximal half resembling pyloric glands and that in the distal half fundus glands with chief and parietal cells. The floor of the ulcer was covered with thin exudate and the wall of the diverticulum in this region showed some evidences of chronic inflammation. Recovery was unevent-

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ful. The child is now quite well fourteen months after operation.

Case II. The second case is unusual in that it began with acute perforation. This case, a well nourished boy of eighteen months, had no history of previous illness. He woke in the night with intense abdominal pain. He cried for two hours, then slept. In the morning he vomited twice and appeared to have pain in the abdomen. I was called, found an acute abdomen, and sent the child to the hospital with a diagnosis of acute appendicitis. Temperature 100.6°, pulse 144, and respiration 28, white blood count 14,700; PMN. 65 per cent. The patient appeared distressed, the thighs were drawn up, but the abdomen was not distended. In the lower right abdomen there was definite local tenderness and moderate muscle spasm. The lower left abdomen was rather soft. An emergency operation was done. Opening of the abdomen revealed an excess of slightly turbid, straw-colored peritoneal fluid. On insertion of the forefinger a small mass was felt which had so recently adhered to the anterior abdominal wall that it was freed at the first touch and presented into the wound. This mass was a small Meckel's diverticulum about one inch long, located on the lower ileum about 18 inches above the cecum. At its base was a punched-out, lenticular perforation, which had adhered to the abdominal wall promptly enough to prevent a frank peritonitis. The operator, Dr. Johnston, commented that the perforation resembled the acute perforation seen at or near the plyorus. The diverticulum was excised with a narrow cuff of intestinal wall, and the opening closed transversely. An appendectomy was also done. The boy recovered promptly. At the time of the operation we were not familiar with the true character of the process with which we were dealing. Subsequent examination revealed that the acute perforation was located in a small chronic ulcer located at the base of the diverticulum. The mucosa of the diverticulum was definitely of gastric character and the fundus-like glands contained chief and parietal cells. The fibrotic thickening of the wall in the region of the ulcer indicated that it was a chronic one.

We have found in the literature a total of seventy-eight cases, all of them reported within the last thirty years, and most of them since 1920. In forty-eight of the cases there was a definite ulcer, and the presence of gastric, duodenal, or pancreatic mucosa was established by microscopic examination. Another group of fourteen cases are definitely identified by clinical and gross pathological findings as examples of peptic ulcer, but give no report of histological examination. In the remaining sixteen cases no ulcer was demonstrated, and while we feel that they too were probably cases of peptic ulcer, yet we have not included them in our statistics.

The age varied from five months to forty-five years, but almost 90 per cent were under sixteen years. Males outnumbered females about five to one.

A single ulcer is usually found, eroding the ileac mucous membrane where it borders the gastric mucosa of the diverticulum. In most instances the ulcer is chronic in type. Multiple ulcers occur occasionally. Several writers emphasize the close analogy with the process occurring at a gastroenterostomy stoma, when an ulcer develops in the mucosa of the jejunum where it adjoins gastric epithelium.

Perforation is reported in about half of the cases. When the perforation is acute it may cause general peritonitis, but the circumstances are favorable to immediate plugging with fibrin, or to sealing by omentum or a loop of intestine. There is evidence that walled off perforations often result from a slow chronic process, which may proceed to the development of peritoneal, mesenteric, or retroperitoneal abscess. The physical findings in cases of walled off perforation may simulate those of appendicitis, appendiceal abscess, or intussusception. Acute perforation followed by diffuse peritonitis presents the usual picture of a very acute surgical abdomen. But in either case, massive intestinal hemorrhage, coincident with or preceding the attack, points strongly to a diagnosis of perforation of peptic ulcer of Meckel's diverticulum. Diagnosis prior to perforation is more difficult. There is no rigidity or tenderness until the inflammatory process has reached the visceral peritoneum. Older children or adults may have abdominal distress, but in the younger cases there may be no evidence of pain even at the time of a large intestinal hemorrhage. Often however, hemorrhage occasions a mild colic which quickly subsides. Physical examination may discover nothing but pallor, and serve only to rule out other possible causes of intestinal hemorrhage.

The blood picture of an acute secondary anemia, with normal bleeding time and clotting time, will eliminate the blood dyscrasias. Leucocytosis is found in the perforated cases. The digestive symptoms of duodenal or gastric ulcer are lacking, and these conditions may further be ruled out by *X*-ray examination. In only one case has the *X*-ray given positive evidence, because the barium does not usually enter the diverticulum. The picture differs from that of intussusception in the lack of intense colic or obstructive signs, and in the absence of mucous in the bloody stool. Rectal polyps should be eliminated by digital and proctoscopic examination. The intestinal hemorrhage from these ulcers is usually massive and recurrent, in contrast to the moderate bleeding which may be found in cases of acute diverticulitis, intussusception, obstruction, or rectal polypi.

Prompt surgical treatment is imperative. If the anemia is profund and the bleeding stopped, preliminary blood transfusion is indicated, but the danger of perforation or further hemorrhage is always present. Under no circumstances should the patient's improved appearance with remission of symptoms lead to postponement of operation. The surgical record is almost perfect, except in the cases of general peritonitis where the mortality is over 50 per cent. All reported cases that were not treated surgically ended fatally.

3144 JEFFERSON AVENUE.

DISCUSSION

L. B. JOHNSTON, M.D., Cincinnati: Meckel's diverticulum, containing gastric mucous membrane, has been described as a "miniature stomach". Observations made on umbilical pouches, which may also contain gastric mucosa, reveal that the taking of food stimulates acid secretion. The ulcers which occur at the junction of gastric and intestinal mucosa are in all respects analogous to gastro-jejunal ulcers. At operation the resemblance of the acute perforation of a Meckel's diverticulum ulcer to that of a pyloric ulcer is very striking. It is interesting that the ulcers occur particularly in infants and children, in whom chronic foci of infection are not demonstrable. The knowledge of these ulcers has done much to revive the biochemical theory of gastric and duodenal ulcer origin. This phase of the subject is thoroughly discussed in a paper written by Lindau and Wulff two years ago. Matthews and Dragstedt have produced ulcers of this type by anastomosing Pavlow pouches to the lower ileum.

The treatment of these cases is surgical. The walled-off perforations and the peritonitis cases obviously demand surgical treatment. It is, however, for the cases which have shown intestinal hemorrhages only that surgical treatment is particularly urged. A study of the literature reveals the fact that over 50 per cent of cases with intestinal hemorrhage will ultimately develop perforation. A definite small number of cases have died of hemorrhage alone. Therefore, if an infant or a child has one or more massive hemorrhages, which cannot be attributed to some cause other than the one which we are discussing, he must be subjected to an exploratory abdominal operation. The operative mortality in this group of cases is exceedingly low. While several cases described in the literature have developed perforation under observation for intestinal hemorrhage of unknown origin, we feel that a very anemic infant or child should be given several blood transfusions during the course of a few days before subjecting him to an operation. It is highly important, however, to not allow the immediate improvement in the general condition of the patient to decide one against operation. If the patient is allowed to leave the hospital without operation he will almost certainly have subsequent hemorrhages and his chances of ultimate perforation of the ulcer are over 50 per cent.

SPINAL ANESTHESIA

By FRED R. KELLY, M.D., and
RALPH M. WATKINS, M.D.,
CLEVELAND, OHIO

FOR this study we have consulted the records of three hundred patients who have received spinal anesthesia at Woman's Hospital between January 1, 1930, and January 1, 1933. There has been no attempt to select special case reports but rather we have examined them almost in order of occurrence during that time. This work was engendered by the opinion of one of us (F. R. K.) that spinal anesthesia is definitely of value in its place and also has a relatively high factor of safety in usage.

The average age of the 300 patients was 42 years, the range varying from 17 to 79 years. There were 180 females and 120 males.

Of the 300 patients, 20 had minor and 280 major operations. The 280 major procedures included 15 cholecystectomies, 45 subtotal or complete hysterectomies, one double breast amputation, 57 inguinal or ventral herniotomies, 182 lower abdominal operations not including hysterectomies but including removal of appendices, uterine adnexa, sections of intestine and so forth.

According to the records 207 of the 300 patients were preoperatively normal except for their surgical diseases. In the remaining 93, there occurred various organic diseases such as chronic renal disease, chronic heart disease and respiratory infections including coryza, asthma, bronchitis and pneumonia. Many of these people were so seriously sick of their accompanying ailments that they were decidedly poor anesthetic and operative risks, and spinal anesthesia was used for this reason. In every instance the anesthetic was injected in the fourth lumbar interspace when it could be entered. Preoperative preparation of the first 235 cases consisted of morphine sulphate, grains ⅛ to ¼, and scopolamine hydrobromide, grains 1/200 to 1/150, given subcutaneously two hours before operation and repeated one half hour before operation unless there was too great depression present. The last 65 cases received 6 grains of sodium amytal three hours before operation and a dose of morphine and atropine, the size depending upon the age and condition of the patient, thirty minutes before operation. Upon arrival at the operating room, the patients were given the intraspinal injection, neocaine and ephedrine being used in the first 20 cases, and spinocaine and ephedrine in the last 280. Then, after five to fifteen minutes, the operation was started if skin anesthesia was present.

Time consumed in operation varied from twenty-five minutes to two hours and forty-five minutes; the patients still retained some degree of anesthesia from two and one-half to five and one-half hours following the completion of the operation.

During the operation about 20 per cent of the patients suffered with nausea and vomiting. In many cases this was associated with manipulation of the gastro-intestinal tract. About 30 per cent complained of itching, especially of the face and neck; about 10 per cent had severe headache; and 5 per cent noted blurring of vision. Twenty-two per cent had abnormal retention of urine

*From the Woman's Hospital, Cleveland, Ohio.

after the operation. In these cases as a rule, the operative procedure had been in the neighborhood of the urinary bladder or rectum.

Vasomotor changes during the operations were numerous. Forty-six of the 300 patients developed abnormal flushing. In almost two-thirds of the patients the respirations during the operation were slower and more shallow than normal. In 58 per cent the pulse was rapid, in 33 per cent slow, and in the balance alternatingly slow and fast. The variations in blood pressure were of unusual interest in that exactly one-half the patients had increased blood pressure during all the course of operation while in the other half the pressure was consistently below the preoperative level. The range of increase varied from 5 to 55 millimeters of mercury and of decrease, from 8 to 75 millimeters.

Not infrequently patients required slight stimulation during operation by means of adrenalin, caffein, digitalis and so forth. In only five cases was it necessary to resort to radical means of stimulation such as artificial respiration or administration of carbon dioxide and oxygen. Supplementary anesthesia consisting of gas and ether was necessary in 34 instances of which five occurred late in a long operation after the anesthetic had worn off. Twenty-six of these patients required additional anesthesia shortly after the start of the operation and these we regard as failures as far as spinal anesthesia is concerned.

The convalescence of 269 patients was entirely uneventful. Of the remaining 31, six or 2 per cent of the whole series developed what we believe to have been post-operative pneumonia. Five others also had pneumonia but in each of these the patient had a definite preoperative respiratory infection. In general the others, who either had a stormy convalescence or who died, were elderly and had serious underlying ailments, usually organic heart or kidney disease, and were operated upon for such dangerous conditions as suppurative appendicitis or strangulated hernia or some other surgical disease of serious outlook.

Sixteen (5.3 per cent) of the patients died. Because of the fact that we are concerned with the comparative safety of spinal anesthesia, we feel that a somewhat detailed report of the deaths is warranted:

1. Male, 59 years; had chronic arterial hypertension and arterio-sclerosis; operation, ventral herniotomy; died of circulatory collapse after ten days.

2. Female, 47 years; had chronic renal disease; operation, removal of bladder stone; died of pyonephrosis and pneumonia after thirteen days.

3. Male, 60 years; had ruptured suppurative appendicitis; operation, appendectomy; died of ileus and peritonitis after ten days.

4. Female, 60 years; had valvular heart disease and asthmatic bronchitis; operation, anterior and posterior colporrhaphy and appendectomy; died of ileus after eleven days.

5. Male, 44 years; had uremia; operation, opening of peri-urethral abscess; died of uremia after five days.

6. Male, 75 years; had carcinoma of pancreas with intense jaundice; operation, cholecystostomy; died as result of carcinoma after three days.

7. Female, 79 years; had chronic myocardial degeneration and bronchial pneumonia; operation, reduction of strangulated hernia; died of the pneumonia after seven days.

8. Female, 53 years; had chronic renal disease and suppurative appendicitis with rupture; operation, appendectomy; died of general peritonitis after eight days.

9. Female, 40 years; had bilateral suppurative salpingitis and pelvic peritonitis; died of post-operative intestinal obstruction after six days.

10. Male, 45 years; had chronic myocardial degeneration; operation, cholecystectomy; died of acute cardiac dilatation after seven days.

11. Female, 53 years; had carcinoma of cecum and ascending colon; operation, ileostomy; died of peritonitis after six days.

12. Female, 22 years; was in the very last stages of toxemia of pregnancy; operation, therapeutic curettage; died from the toxemia in eight hours.

13. Female, 74 years; had chronic renal disease and suppurative appendicitis with rupture; operation, appendectomy; died of ileus and peritonitis after seven days.

14. Female, 52 years; had carcinoma of the sigmoid colon; operation, resection; died of peritonitis after five days.

15. Male, 42 years; had urethral stricture and uremia; operation, posterior urethrotomy; died of uremia after four days.

16. Male, 70 years; had chronic renal disease and chronic myocardial degeneration; operation, prostatectomy; died of pulmonary embolus after nine days.

LITERATURE

Spinal anesthesia in urological examination and surgery has been highly recommended by Bumpus[1] and Shute[2]. Davis[3] states that sacral block is the ideal method of anesthesia for perineal prostatectomy. Seavers and Waters[4] believe that the use of spinal anesthesia should not be routine but should be dependent upon proper selection of risks with regard to the absolute necessity for complete muscle relaxation and the ability of the patient to oxygenate his tissues normally. They do not believe it wise to cause block of the major thoracic regions in spite of the enthusiastic claims of some who advise spinal anesthesia for operations on the head and neck.

Koster and Weintrob[5] report six deaths of 6,000 surgical cases in which spinal anesthesia probably was responsible. On the other hand, Rygh and Bessesin[6] have collected the records of over 215,000 cases in which there have been a total of 75 deaths, a rate of one in about 2900 cases.

Koster and Weintrob[7] have analyzed all the deaths from spinal anesthesia reported in the

literature as thoroughly as possible and find that in most instances the patients were very poor operative risks, in fact, many being almost moribund at the time of operation. They report 1010 cases given spinal anesthesia in which there followed eighteen respiratory complications without fatality and compare them to 1562 operations done with inhalation anesthesia in which there were 55 pulmonary complications and eleven deaths.

Bogart[5] reports 152 patients who were operated upon under spinal anesthesia, neocaine being used. Many cases were in the extreme stage. No fatality attributable to the anesthesia occurred. He says, "Spinal anesthesia is a safe procedure, allowing the surgeon greater freedom of manipulation and conducive to less trauma resulting in greater comfort to the patient and a smoother convalescence."

DISCUSSION

There are certain points which we would like to discuss in connection with the general subject of spinal anesthesia and with reference to the series of cases which we have reported.

1. We feel that it is worth while to note that in the last 100 cases our technic has been changed as follows:

A. The patient is turned on his abdomen for three to five minutes following the injection of the spinocaine into the subarachnoid space, and is placed in the Trendelenberg position, the degree depending on the height of anesthesia desired.

B. Moderate to marked Trendelenberg position is used after ten minutes to combat the expected fall in blood pressure.

C. The patient is encouraged to inhale and exhale forcibly to insure adequate aeration of the lungs when a high level of anesthesia is necessary.

D. To avoid the deep depression frequently encountered after the use of morphine and scopolamine we have recently been using sodium amytal in preoperative preparation and consequently developing only moderate narcosis. It may be remembered that in the 300 cases we have reported 26 anesthetic failures. It is of interest to note that only three of the last 100 administrations have failed, as a result of our change in technic.

2. In the literature there are many reports of comparatively high mortality from the use of spinal anesthesia. It is noteworthy that the highest fatality rates are reported in the smaller series of cases. In the hands of anesthetists who have administered spinal anesthesia hundreds or thousands of times, the mortality is low. This speaks for experience in using this type of anesthesia. It should not be given by inexperienced operators.

3. One of the greatest objections to the use of spinal anesthesia has been the fall in blood pressure during operation. This has sometimes reached alarming degrees. We feel somewhat elated that in half our cases the blood pressure rose instead of falling. We feel certain that with the new technic a drop in blood pressure of serious degree can be obviated. In the last 100 cases the fall in blood pressure was moderate in four, slight in 43 and in the balance, 53 cases, there was no fall at all in blood pressure. Only three of these 100 patients required mild stimulation during operation.

4. One of the patients had suffered with severe recurrent headaches for ten years previous to our use of spinal anesthesia on him in the repair of a hernia. Since that time, a period of two and one-half years, he has been entirely relieved of severe headaches.

5. There occurred six instances of post-operative pneumonia in patients who had no preoperative respiratory infection as far as could be ascertained. None of these were fatal. Whether or not these can be attributed to the type of anesthetic we are not prepared to state.

6. We have been much interested in studying the findings of the patients who died, a subject of great importance. There were sixteen deaths. In almost every case the patient was suffering from some very serious surgical condition necessitating radical procedure; further, the majority of these patients had chronic underlying degenerative diseases usually of the cardio-vascular-renal system. In other words, they represented poor surgical risks. With one exception they lived from three to twelve days before succumbing to the surgical condition or their underlying disease. We feel that they would have died regardless of the type of anesthetic used. Obversely, we do not believe that any of the patients died as a direct result of spinal anesthesia.

CONCLUSION

From our study of the records of 300 patients who received spinal anesthesia we believe that the following points may be emphasized:

1. Only one-half the patients experienced a fall in blood pressure during the operation and this condition has been somewhat alleviated by recent improvement in technic.

2. Of the sixteen patients who died, we feel that none died as a result of the method of anesthesia used.

In the words of Romberger[9], "The practice of medicine, in all its branches, is a progressive science; he who stands still for the briefest part of a decade is soon left hopelessly behind. The world moves and we must move with it. Any hospital, or surgeon, or anesthetist who stands obstructingly upon the right of way of the onrushing train of progress likely will be found among the debris and wreckage by the wayside. I believe that spinal anesthesia is here to stay; because, in its modern exemplification, many advantages ac-

crue to both the patient and the surgeon. It is reasonable and rational; it is accurate and scientific; it is controllable; it is safe."

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New Books Received

New and Nonofficial Remedies, 1934, containing descriptions of the articles which stood accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1934. Cloth. Price, Postpaid, $1.50. Pp. 510; lx. Chicago: American Medical Association.

New and Nonofficial Remedies, 1934, has the same pleasing format and helpful mechanism that has characterized it in past years. The enrichment of the indexing started a few years ago is continued and its value even increased by some desirable simplification of cross references.

The Council has made the usual careful revision of the book. The general article Lactic Acid-Producing Organisms and Preparations has been practically rewritten. The chapter on Arsenic preparations has undergone some revision, especially in the statement concerning Neoarsphenamine. The descriptions of Chiniofon and Vioform have been revised in the light of recent developments in the treatment of amebiasis. The article on Ethylhydrocupreine has been revised to delete references to Optochin Base, which has been omitted; Optochin Hydrochloride has been retained, being recommended only for external use. The description of Typhoid Vaccine has been revised to give the dosage of the combination of typhoid and paratyphoid organisms and to mention the use of typhoid vaccine in nonspecific protein therapy. A number of revisions of the Council's Rules have been made, particularly with reference to the names of products.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1933. Cloth. Price, postpaid, $1.00. Pp. 188. Chicago: American Medical Association.

The main bulk of the volume, which is, incidentally, considerably increased over that of recent annual volumes, is taken up with reports on products which the Council has found unacceptable for inclusion in New and Nonofficial Remedies. Of special note are: The report on Alpha-Lobelin, a drug upon which the Council in 1927 issued a preliminary report but which is now found not to have established itself as a respiratory stimulant of as great usefulness as carbon dioxide and oxygen; the report on a number of preparations marketed by the Upjohn Company with unwarranted, misleading and unscientific claims; the report on Clavipurin, a preparation of the alkaloids of ergot, marketed without adequate declaration of the composition and without adequate standardization under a nondescriptive proprietary name with unwarranted therapeutic claims; the report on Diampysal, another pyridine derivative proposed for use in bacterial infections, convincing evidence for the therapeutic value of which is lacking; the report on Euphydigital, an irrational mixture of digitalis and a theophylline preparation marketed under an uninforming, proprietary name, with exaggerated and unwarranted claims for its therapeutic value; the report on Guphen, stated to be the guaiacol ester of phenylcinchoninic acid, marketed with unwarranted therapeutic claims under an uninforming, proprietary name and having no proved advantage over its constituents administered separately; the report on Niazo, a pyridine compound of unsubstantiated value as a urinary antiseptic; the report on Omnadin, a preparation recognized for use for nonspecific lipoprotein therapy practically as a cure-all; and the report on a group of endocrine preparations of the Rovin Laboratories variously unacceptable as being of indefinite composition and of undemonstrated therapeutic value.

A feature of marked current interest in this volume is the preliminary report on Alpha-Dinitrophenol, the new drug for acceleration of cellular metabolism. The Council voices a warning on the dangers attending the use of this drug; this warning has been increasingly justified in reports of fatalities since the appearance of the Council's report in July of last year. Other preliminary reports which make this volume one of the most interesting issued by the Council in recent years are those on Dilaudid, a new narcotic drug related to morphine; Fuadin, a new antimony compound for use in the treatment of bilharziasis and granuloma inguinale; and Hippuran, a new product for intravenous and oral urography. The comprehensive and definitive special report on estrogenic substances furnishes a much needed review of the present status of such products in gynecologic therapy. The Council insists upon the doctrine that basic laboratory investigation of these substances should precede clinical use.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

The Importance of the American Medical Association

Within the coming fortnight the American Medical Association will convene in the city of Cleveland. This great association, of which our own is a component part, has met in this state only five times since its formation. The first meeting on Ohio soil was in Cincinnati in 1850 and the last was in Columbus in 1899. The convention has met in Cleveland only once before, and that was fifty-one years ago. It seems strange that thirty-five years have elapsed since the physicians of this important and populous state have had the opportunity of entertaining the parent organization, but that fact alone makes us all the more eager to extend cordial hospitality now. Together with the profession of Cleveland, the members of our State Association share the privileges and responsibilities of acting as hosts to their professional colleagues who will come to Cleveland from every state in the Union and from many foreign countries.

Ohio is very close to the nation's center of population. Cleveland is readily accessible both by rail and motor routes. Its centrally located Public Hall, large enough to house comfortably all sections and both the scientific and technical exhibits, and its conveniently situated and commodious hotels, are adequate to take care of the largest conventions. These facts, together with the splendid instructive program provided, insure a large attendance.

In anticipating this meeting, while we naturally think of our duties as hosts first, we must also remember that its presence in our state gives us a wonderful opportunity for bringing our knowledge of medicine up to date with a minimum of inconvenience, expense, and loss of time. The purpose of the annual meetings is primarily educational, and this is fulfilled in four ways. First come the section meetings, which afford opportunities of hearing papers and discussions in all branches of medical science. Then there are the general scientific meetings, originally started as the clinical lecture program, but now greatly expanded and improved. They will be held on Monday and Tuesday, June 11 and 12, and will be devoted to the presentation of thoroughly practical contributions by well qualified men. For example, the entire afternoon session on Tuesday will be devoted to a symposium on the timely subject of amebiasis with seven contributors, the general subject being fully covered beginning with epidemiology and concluding with complications and sequelae. The third educational feature is the scientific exhibit, which has steadily grown until it is now a major activity. This exhibit alone would be well worth a journey to Cleveland, and many physicians of inquiring and receptive mind spend hours in studying the exhibits, which are designed and executed to have the utmost teaching value. The fourth major feature is the technical exhibit, which in its display of text-books, medical, surgical, laboratory and hospital equipment, pharmaceutical preparations and scientific food products is of great interest and practical value. The Academy of Medicine of Cleveland and the Ohio State Medical Association have appointed committees to arrange for the entertainment of the convention and its visitors. Careful plans have been made, and we ask for your whole-hearted interest and support.

In recent years there have grown up organizations which have attracted considerable popular support. Organized and controlled by small groups, they give opportunity only to a relatively few to appear on the programs. There is a substantial fee for the privilege of registration and those who register receive nothing except the privilege of attending the sessions. No services are rendered the members throughout the year.

On the other hand, the conventions of the American Medical Association are the members' own, sponsored and supported by them, giving large opportunities to the members for participation in the programs. The control is by a form of representative self government patterned after our federal national government. Financial affairs are subject to detailed report and responsible audit. No promoter receives personal profit from its operations. Its annual dues include not only the right to attend a great graduate teaching convention, but also the subscription to that remarkable medical weekly, the *Journal of the American Medical Association*, as well as *Hygeia* and many special journals. Support of the American Medical Association aids in the maintenance of many activities rendering invaluable service year after year to the physician and to the public. These include the Councils on medical education and hospitals, pharmacy and chemistry, foods, physical therapy, and the Bureaus of legal medicine and legislation, medical economics, and health and public instruction.

All these facts are compelling reasons for every member of this State Association to be not only a member of the American Medical Association, but a *Fellow* as well. A member in the Ohio State Medical Association is thereby automatically a member of the American Medical Association but *to become a Fellow*, he must pay the fellowship dues, amounting to $7.00 a year. In return for this investment, he receives *The Journal* and is entitled to the privilege of attending the annual meeting without additional fee. If you are not a Fellow, we urge you to become one at once; and if you are a Fellow or become one, plan to attend the Cleveland meeting and support your own great national organization.

COUNCIL OF STATE ASSOCIATION ACTS ON NUMEROUS IMPORTANT QUESTIONS AT ITS MAY MEETING

MINUTES

The Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, at 1:00 P. M. on Sunday, May 13, 1934.

Officers, Councilors and committeemen present were: President, Dr. Cummer; President-Elect, Dr. Caldwell; Ex-President, Dr. Platter; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Paryzek, Davidson, Shanley, Brush and Seiler; Dr. Stone, chairman, and Dr. Upham, member Policy Committee; Dr. Rogers, chairman, Publication Committee; Dr. Southard, State Director of Health; Dr. Verne A. Dodd, President of the Columbus Academy of Medicine; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on March 11, 1934 (pages 237 to 241, inclusive, of the April, 1934, issue of *The Journal*), were read, and on *motion* by Dr. Davidson, seconded by Dr. Smith and *carried*, were *approved*.

1934 ANNUAL MEETING

Dr. Paryzek, chairman of the Council Program Committee, reported in detail on the program thus far completed for the General Sessions and Section meetings for the forthcoming annual meeting of the Ohio State Medical Association to be held in Columbus on Thursday, Friday and Saturday, October 4, 5 and 6, 1934.

Dr. Paryzek also reported on prospects for scientific exhibits, and the Council extended to his committee power to act on this matter in conjunction with the local Scientific Exhibits Committee.

The general tentative schedule recommended by Dr. Paryzek's committee is as follows:

First Day

9:00 to 10:45 A. M.	Opening General Session and House of Delegates.
11:00 A. M. to 12:30 P. M.	General Session.
12:30 P. M.	Open for reunions.
2:15 P. M.	Six Scientific Section meetings. Five papers in each Section limited to fifteen minutes each.
8:00 P. M.	General Session. Annual addresses of the retiring and the incoming presidents, entertainment and an address by a popular speaker.

Second Day

9:00 to 10:00 A. M.	General Session. Two scientific addresses.
10:00 A. M. to 12:00	Noon Symposium by staff members of the College of Medicine, Ohio State University.
12:00 Noon	Organization Luncheon.
2:15 to 3:15 P. M.	General Session. Scientific address.
3:30 P. M.	Second and last session of the House of Delegates.
6:00 P. M.	Banquet. Prominent speaker.

Third Day

9:00 to 10:00 A. M.	General Session. Scientific address by prominent out-of state speaker.
10:00 A. M. to 12:00 Noon	Six Scientific Section meetings. Five papers in each Section limited to fifteen minutes each. Election of Section officers for 1935 annual meeting.
12:00 Noon	Adjournment.

Upon *motion* by Dr. Paryzek, seconded by Dr. Caldwell and *carried*, the report was approved by the Council subject to changes as contained in his report and subject to future substitutions or rearrangements that might be found necessary.

Dr. Verne A. Dodd, President of the Columbus Academy of Medicine, reported that local committees had been organized and that the local profession would do everything possible to insure the success of the meeting in Columbus in October. He submitted for the information and consideration of the Council a discussion by the Council of the Columbus Academy of Medicine relative to a banquet on Friday evening of the annual meeting.

After discussion by members of Council, on *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the Council expressed its approval of the arrangements whereby the Columbus Academy of Medicine should assume the responsibilities for a banquet, with the exception that the State Association, through the Program Committee of Council, would provide an outstanding speaker on social, governmental or economic questions. Dr. Paryzek requested members of Council to submit to him recommendations for a speaker on this occasion.

Dr. Stone, general chairman of the local com-

mittees on arrangements for the annual sessions of the American Medical Association to be held in Cleveland on June 11 to 15, inclusive, reported in detail on the plans and arrangements and called attention to the program as published in the May 12 issue of *The Journal of the American Medical Association.* He supplemented that report with announcements on the details of entertainment. His report was accepted and approved by the Council.

Pursuant to authorization by the Council at its last meeting, Dr. Cummer announced the appointment of representatives from the Ohio State Medical Association on local committees for the A. M. A. meeting as follows: *Finance Committee,* Dr. Barney J. Hein, Toledo. *Committee on President's Reception,* Drs. H. L. Sanford, chairman, Cleveland; J. Craig Bowman, Upper Sandusky; John A. Caldwell, Cincinnati; E. M. Huston, Dayton; J. H. J. Upham, Columbus, and Edmund A. Weeks, Akron. *Entertainment Committee,* Drs. L. L. Bigelow, Columbus; E. R. Brush, Zanesville; C. R. Clark, Youngstown; C. L. Cummer, Cleveland; J. P. DeWitt, Canton; Geo. Edw. Follansbee, Cleveland; Albert H. Freiberg, Cincinnati; D. C. Houser, Urbana; C. E. Kiely, Cincinnati; Ben R. McClellan, Xenia; Wells Teachnor, Columbus; A. Howard Smith, Marietta; Carl R. Steinke, Akron, and C. W. Waggoner, Toledo.

On *motion* by Dr. Seiler, seconded by Dr. Paryzek and *carried,* the Council approved the appointment of the foregoing committees.

STIMULATION OF LOCAL PROGRAMS

Dr. Cummer, the President, reported on correspondence and conferences with various members relative to problems in the formulation of programs for the county medical societies. He emphasized the importance of stimulating local interest and attendance through participation by local members in the programs and other activities of the societies. He called attention to a plan devised some years ago by Dr. J. A. Weitz, Montpelier, then secretary of the Williams County Medical Society, for "study outlines" on subjects of general importance. Other members of the Council called attention to the danger of gradually decreased interest in county society meetings where speakers from a distance were secured regularly and where local men were not encouraged to participate in the preparation and presentation of papers and in the general discussion of scientific subjects, or through case reports, etc.

On *motion* by Dr. Hein, seconded by Dr. Beer and *carried,* the President was empowered and requested to appoint a committee to formulate suggested "study outlines" on scientific subjects of general interest and for the greater utilization of "home talent". Dr. Cummer announced that the report of such committee would be published in *The Journal* with suggested outlines for adaptation as the county society program committees might desire.

PREVENTIVE MEDICINE

Dr. Cummer reported on the meeting of the State Association Committee on Preventive Medicine and Periodic Health Examinations held in Columbus on March 25. The minutes of that meeting were read.

On *motion* by Dr. Platter, seconded by Dr. Klotz and *carried,* the Publication Committee and Executive Secretary were requested to give appropriate publicity to the proposed program of meetings by the Ohio Committee of the American Academy of Pediatrics during the coming summer and early fall, but with the understanding that the State Association should assume no financial responsibility or officially endorse activities of another organization, this being in accordance with definite policy already established.

On *motion* by Dr. Klotz, seconded by Dr. Seiler and *carried,* a recommendation of the Committee on Preventive Medicine and Periodic Health Examinations was approved for the preparation of a brief newspaper release on pre-natal care through the State Department of Health, and which release would be issued locally and properly localized by the local health commissioners. The President announced that the committee to formulate such a newspaper release would consist of Dr. Southard, Dr. Skeel and the Executive Secretary.

Attention was called to the issuance through the Nutrition Division of the State Relief Commission of nutritional information accompanied by detailed diets to apply to individuals on direct relief, especially in the utilization of cheaper foods, and which information might be utilized by the local relief commissions and the physicians who are attending under-nourished children, aged persons and diabetics particularly. Attention was also called to a statement contained in these announcements and charts to the effect that the instructions were prepared by a committee of the Ohio Dietetic Association and approved by the Committee on Preventive Medicine of the Ohio State Medical Association. Reference was made to the fact that this matter had not been reported to or discussed by the Committee on Preventive Medicine and Periodic Health Examinations at its recent meeting.

On *motion* by Dr. Shanley, seconded by Dr. Seiler and *carried,* the Executive Secretary was requested to secure information on this matter.

HOSPITAL PROBLEMS

A report was submitted by the President on the formulation of a detailed memorandum of complaints by physicians against some hospitals. This memorandum was discussed in detail. On

motion by Dr. Davidson, seconded by Dr. Brush and *carried*, this memorandum was approved and placed in the hands of the Policy and Judicial Committees for further negotiations and conferences with officials of the Ohio Hospital Association with the request that efforts be made through mutual cooperation to arrive at satisfactory solutions of whatever dierences and difficulties may exist. In this connection, the attitude of the outgoing president of the Ohio Hospital Association, Mr. B. W. Stewart of Youngstown, was commended for his expressed desire for conferences and cooperation.

MEDICAL RELIEF PROBLEMS

Dr. Stone, Dr. Cummer and Dr. Southard reported on recent developments in connection with the administration of direct relief to the needy, including medical care to indigents. Correspondence was submitted on this subject and a detailed report was read showing a tabulation of reports from all the counties through the local relief directors. This information was supplemented by correspondence from officers and members of county medical societies. Special attention was called to the latest published details on developments, including revised plans and setup for those injured in the Work Division of the FERA, the abandonment of the CWA, plans for per capita appropriation to each local relief district through the State Relief Commission for medical care each month, plans and report forms for more prompt submission of bills and payment for services rendered (page 314 of the May 1 issue of *The Ohio State Medical Journal*).

WORKMEN'S COMPENSATION

Dr. Hein, chairman of the Special Committee on Workmen's Compensation of the State Medical Association, and Dr. Cummer reported on recent conferences with the Governor's Committee on Workmen's Compensation Investigation. A report was submitted on recent legislation enacted by the Ohio General Assembly to transfer control and appointment of personnel in the Workmen's Compensation Division from the Department of Industrial Relations to the Industrial Commission. (News article elsewhere in June 1 issue of *The Ohio State Medical Journal*).

Reports were submitted on recent public hearings held by the Governor's Committee on Workmen's Compensation Investigation at which a number of recommendations previously made by the Workmen's Compensation Committee of the State Medical Association (pages 318 to 320 of the May, 1934, *Journal*) were supported.

Dr. Hein explained the request from Mr. S. P. Bush, the chairman of the Governor's investigating committee, for the formulation by his committee of the State Association of detailed plans on the establishment of regional medical boards of review as previously recommended by the committee of the State Medical Association. Further report was made on present problems of administration at the Industrial Commission.

REPORT ON "HONORARY MEMBERSHIPS"

On behalf of the Judicial Committee of Council, Dr. Platter, the chairman, presented the following report:

Report

At the last meeting of the Council held on March 11, there was submitted to the Special Judicial Committee for consideration and report a question raised by the secretary of one of the component county medical societies in relation to the practicability of establishing honorary memberships in the State Association upon certification by the county societies, through amendment to the Constitution and By-Laws of the State Association.

Your Judicial Committee has considered this question from a number of angles, and has secured information on the attitude of members of former committees charged with the responsibility of submitting revisions and amendments to our Constitution.

Attention is called to Section 4 of Chapter I of the By-Laws, providing for "one class of members only". This, of course, means *active* membership upon certification and transmission of dues to the State Association headquarters through the secretary or secretary-treasurer of the component society.

Section 5 of Chapter I of our By-Laws reads as follows:

> "CLASSIFICATION OF LOCAL MEMBERS. If any component society provides for a diversified classification of its members, dues for them in The Ohio State Medical Association shall be collected and transmitted to the executive secretary of this Association or appropriated from the funds of the local society. Exempted from this provision are such local members who are not eligible for membership in this Association under the requirements of Section 4 of this Chapter, and such as are still serving as hospital interns on full time on a nominal salary, such as have retired from active practice of medicine, and non-resident members who are members of organized medicine in good standing in the county in which they reside."

Upon inquiry we find that difficulties frequently arise in the component societies and academies of medicine where diversified classes of members are provided. Misunderstandings have arisen on occasions when honorary or retired members of component societies assume that their membership was continuous in the State Association, perhaps through lack of information on the part of the county societies when such types of memberships were extended to those who had previously been in the classification of active members.

It is the opinion of your committee that if provision should be made for more than one class of membership in the State Association, confusion would be multiplied, especially when component societies have different provisions and qualifications for such diverse classification of members. In other words, honorary or retired members in the State Association would be certified on varying bases from component societies. Some members not designated as honorary or retired members and exempt from dues might feel that they were unjustly discriminated against.

Your committee feels that the provisions in Section 5 of Chapter I of our By-Laws quoted above are reasonable and correct. Component societies which desire to do so may grant various types of memberships, and in the case of hon-

orary or retired memberships they may either appropriate the membership dues in the State Association from the society treasury or collect the annual per capita dues in the State Association from such member who is relieved of membership dues in his local society.

It will be remembered that some years ago before the Constitution was thoroughly revised in 1919, that more than one type of membership was provided in the State Association. Based on that experience which led to confusion, the Constitution and By-Laws were revised, and since that year only one type of membership, that of active membership, has been provided in the State Association. It is our belief that this provision has been uniformly fair and generally satisfactory.

In rare cases of elderly or disabled physicians who have long been active members in the State Association but who because of age or disability have retired from practice, may properly be designated as honorary or retired members in their county societies. In such cases, upon agreement by the President of our State Association in connection with our headquarters office, in properly selected instances, such members may continue to be retained on the mailing list to receive *The Journal* regularly. This arrangement can be made without any constitutional amendment and its resulting confusion. As a matter of fact, this custom has been observed in several instances by a number of former presidents where special consideration and recognition is deserved upon the part of retired or disabled former members.

It is our recommendation that the foregoing statement and policy be adopted by the Council.

Special Judicial Committee to the Council,
H. M. Platter, M.D., Chairman,
John A. Caldwell, M.D.,
I. P. Seiler, M.D.

On *motion* by Dr. Platter, seconded by Dr. Brush and *carried*, the Council adopted the foregoing report.

OTHER JUDICIAL QUESTIONS

Dr. Platter reported on a communication received from Dr. C. E. Savage, Delphos, Ohio, under date of April 12, addressed to the Council and pertaining to his suspension from the Academy of Medicine of Lima and Allen County.

On *motion* by Dr. Platter, seconded by Dr. Smith and *carried*, the Executive Secretary was instructed to request the secretary of the Academy of Medicine of Lima and Allen County for a copy or detailed information on the procedure of that society in connection with Dr. Savage's suspension or expulsion, for consideration by the Council at a later meeting.

PROPOSED AMENDMENTS

Dr. Hein reported on a suggested proposal for amendments to the Constitution and By-Laws for greater utilization of the judgment and experience of former presidents through extension of their periods of service on the Council and provision for their membership as delegates-at-large in the House of Delegates. This matter was discussed in detail by several Councilors. Action was deferred for further information and discussion at the next Council meeting.

GROUP AND SOCIALIZED PROJECTS

Upon the request of Council, Dr. Upham, chairman of the Board of Trustees of the American Medical Association, analyzed in detail developments in connection with correspondence and conferences with officials of the Michigan State Medical Society. He analyzed the resolution adopted by the House of Delegates of that society at a special meeting on April 12, 1934, published as a supplement to the May, 1934, *Journal of the Michigan State Medical Society*, and in which is recorded official action by a vote of 61 to 9 on the adoption of a resolution favoring experimentation for "Mutual Health Service" on an insurance basis applicable to employes whose annual incomes do not exceed $1,500.

Copies of the Proceedings of the House of Delegates of the Michigan State Medical Society were distributed to the members of Council with the request from the President for careful study. Attention was called to the fact that serious problems of state medicine and socialization would undoubtedly come before the House of Delegates of the American Medical Association at its meeting in Cleveland in June. Correspondence was considered in relation to governmental tendencies through various federal departments.

A brief report was submitted on the group hospital insurance plans in a number of Ohio cities, and reference was made to previous Council action on medical and hospital group plans (December, 1933, issue of *The Journal*, page 777, and April, 1934, issue of *The Journal*, page 239.

LEGAL AND LEGISLATIVE

Dr. Stone reported on recent correspondence with the Committee on Judicial Administration and Legal Reform of the Ohio State Bar Association, in relation to physician members on a proposed state commission to consider and recommend new legislation in Ohio with regard to marriage, divorce and domestic relations.

On *motion* by Dr. Seiler, seconded by Dr. Paryzek and *carried*, the action of the President as expressed in recent correspondence on this matter was approved.

For the information of the Council, Dr. Stone reported on correspondence pertaining to the subject of bankruptcy and the position of physician creditors in these proceedings. He also read a communication under date of April 3, 1934 from Dr. W. C. Woodward, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, on this subject, in reply to an inquiry from the headquarters office of the Ohio State Medical Association. Dr. Stone announced that the analysis and attitude

expressed by Dr. Woodward met the approval of the Policy Committee of the State Association.

On behalf of the Policy Committee, Dr. Stone reported on the session of the Ohio General Assembly recently recessed, and analyzed the various pending taxation proposals. He explained the prospects for other special sessions. He discussed the medicinal liquor situation. He pointed out the prospects for the introduction of further legislation directly affecting the medical profession and urged the Councilors to stimulate interest on the part of legislative committeemen, officers and members of the county societies in their respective districts in contacting candidates for the Legislature and explaining to them the attitude of the medical profession.

MEDICAL DEFENSE PROBLEMS

A report was submitted by the Medical Defense Committee through the President on recent developments and increased problems in connection with malpractice and medical defense. Reference was made to recent correspondence and conferences on this subject, including information on the attitude of some indemnity insurance companies toward their policyholders in specific instances, and the change in wording in the policies issued by some companies.

Following discussion by several members of Council, on *motion* by Dr. Shanley, seconded by Dr. Seiler and *carried*, the Executive Secretary was requested to communicate with the American Medical Association and urge the preparation of a summarized comparison of malpractice indemnity insurance policies of the various companies, together with a summary of financial information and experience of the indemnity companies.

MEDICAL EMBLEM

Upon the request of the Council at its last meeting, Dr. Rogers submitted a report based on correspondence which criticized the medical emblem used on the *State Medical Journal* and in the official seal.

He summarized the history of the staff of Aesculapius and the caduceus of Apollo. He pointed out that according to mythological history the staff of Aesculapius has become the authentic emblem of the medical profession, but that mythological history indicated that Aesculapius, the son of Apollo, had received his medical knowledge from the former, that according to medical historical authorities, including recognized medical dictionaries, as well as the action of the federal government, the Army and Navy, the caduceus of Apollo was recognized as an official emblem of medicine and of the medical profession. He pointed out that on account of the symmetry of the caduceus, it lends itself more readily to artistic design.

On *motion* by Dr. Huston, seconded by Dr. Brush and *carried*, the Council declined to consider a change at this time in the official seal of the Ohio State Medical Association, and the medical emblem used in the *State Medical Journal* in which the caduceus is reproduced.

MEMBERSHIP STATISTICS

The President called attention to membership data showing a total of 4,939 paid members in the State Association to date for 1934, as compared with a total of 4,676 on the same date in 1933 and as compared with a total at the end of 1933 of 5,183. This tabulation also showed that 56 of the county societies and academies of medicine show a total membership to date for 1934 as great or greater than for the entire year 1933. On account of the serious problems confronting the medical profession at this time, Dr. Cummer urged the Councilors to endeavor to stimulate membership in their respective districts, in order that the profession might be strengthened and its effectiveness increased and that its service to the members in the promotion and protection of their interests might be correspondingly enhanced.

There being no further business presented for consideration, the Council adjourned to meet at the call of the President.

Signed:

JAMES A. BEER, M.D.,
Secretary of Council.

— OSMJ —

Personnel Secretary is Appointed by State Industrial Commission

Albert D. Caddell, Mansfield, has been appointed by the State Industrial Commission as secretary of the Commission in charge of personnel.

Mr. Caddell's appointment was the first official action taken by the Commission under the authority of legislation enacted at the recent session of the Ohio Legislature giving the Commission jurisdiction over the personnel employed in administration of the Ohio Workmen's Compensation Law.

Mr. Caddell was secretary of the Mansfield Chamber of Commerce, secretary of the Mansfield Manufacturers' Association, secretary-treasurer of the Manufacturers' Association of Central Ohio and a member of the Ohio Industrial Council. He has had considerable executive experience, having been associated for a number of years with watch manufacturing firms in Mansfield and Canton.

— OSMJ —

The Fourth International Congress of Radiology will be held at Zurich and St. Moritz, Switzerland, July 24-31. Delegations from all the leading nations will attend.

RECORD ATTENDANCE EXPECTED AT ANNUAL SESSION AMERICAN MEDICAL ASSOCIATION IN CLEVELAND, JUNE 11 TO 15th

Arrangements have been completed for the Eighty-Fifth Annual Session of the American Medical Association in Cleveland, June 11-15, and present indications are that in many respects the Cleveland session of the A.M.A. will be the most important, most instructive and most interesting gathering ever held by the national organization.

The medical profession of Cleveland, through its local committees, the personnel of which were listed in the May, 1934, issue of *The Journal*, has done its utmost to qualify as the ideal host to the medical profession of the country. A splendid program of entertainment, supplementing the scientific program and business sessions of the House of Delegates, has been arranged. In carrying out the innumerable details preliminary to the meeting, the Cleveland profession has received the assistance and cooperation of The Council of the State Association.

Upon authorization of The Council and at the request of Dr. C. W. Stone, general chairman of the Cleveland committees on arrangments, Dr. C. L. Cummer, the President, has appointed the following to represent the State Association on three of the important Cleveland committees during the A.M.A. session:

Finance—Dr. B. J. Hein, Toledo, chairman of the Council Committee on Auditing and Appropriations.

President's Reception—Dr. H. L. Sanford, Cleveland, previously designated as chairman of that committee, Dr. J. H. J. Upham, Columbus, Dr. E. M. Huston, Dayton, Dr. John A. Caldwell, Cincinnati, Dr. J. Craig Bowman, Upper Sandusky, and Dr. E. A. Weeks, Akron.

Entertainment—Dr. A. H. Freiberg, Cincinnati, Dr. C. R. Clark, Youngstown, Dr. D. C. Houser, Urbana, Dr. L. L. Bigelow, Columbus, Dr. Wells Teachnor, Columbus, Dr. Ben R. McClellan, Xenia, Dr. E. R. Brush, Zanesville, Dr. J. P. DeWitt, Canton, Dr. C. E. Kiely, Cincinnati, Dr. C. W. Waggoner, Toledo, Dr. Carl R. Steinke, Akron, Dr. Howard Smith, Marietta, and Dr. C. L. Cummer, Cleveland.

Although complete information and data relative to the Cleveland meeting, together with the preliminary program of the scientific assembly, were published in the May 12, 1934, issue of *The Journal of the American Medical Association*, for the information of Ohio physicians who may not have read that issue of *The Journal, A.M.A.* and by way of emphasis, some of the high spots of the arrangements and program will be summarized.

The meeting will open at 10 a. m. Monday, June 11, with a meeting of the House of Delegates in the ballroom of the Hotel Statler. The State Association will be represented in the House of Delegates by the following delegates and alternates: Drs. Wells Teachnor, Columbus, Ben R. McClellan, Xenia, E. R. Brush, Zanesville, C. W. Stone, Cleveland, J. P. DeWitt, Canton, C. E. Kiely, Cincinnati, C. W. Waggoner, Toledo, and Drs. Carl R. Steinke, Akron, A. C. Messenger, Xenia, A. Howard Smith, Marietta, C. L. Cummer, Cleveland, G. F. Zinninger, Canton, L. H. Schriver, Cincinnati, Charles Lukens, Toledo.

In addition an important part in the proceedings of the House of Delegates will be taken by Dr. J. H. J. Upham, Columbus, chairman of the Board of Trustees of the American Medical Association, and Dr. Geo. Edw. Follansbee, Cleveland, chairman of the A.M.A. Judicial Council. Dr. Ross B. Bretz, Cleveland, will serve as a delegate representing the United States Army Medical Corps. Three Ohio physicians are members of official bodies of the A.M.A. whose reports on activities for the past year (May 5, 1934, issue of *Journal A.M.A.*) will be submitted to and acted upon by the House of Delegates. They are: Dr. Torald Sollmann and Dr. H. N. Cole, both of Cleveland, members of the Council on Pharmacy and Chemistry, and Dr. Howard T. Karsner, Cleveland, member of the Council on Physical Therapy.

DINNER FOR OFFICERS AND DELEGATES

On the evening of Monday, June 11, the Cleveland Academy of Medicine and the Ohio State Medical Association will be hosts at a dinner and reception at the Union Club for the general officers and members of the House of Delegates of the American Medical Association.

Three general scientific meetings will be held—June 11 at 2 p. m. and June 12 at 9:30 a. m. and 2 p. m. Programs will be presented by the scientific sections on Wednesday, Thursday and Friday, June 13, 14 and 15. The opening general meeting will be held at 8 p. m. June 12, with Dr. Dean Lewis, president of the A.M.A., presiding. Addresses of welcome will be made by Mayor Harry L. Davis, Cleveland, Dr. A. A. Jenkins, president of the Cleveland Academy of Medicine, and Dr. C. L. Cummer, president of the Ohio State Medical Association. United States Senator Robert J. Bulkley, Cleveland, will speak and Dr. Walter L. Bierring, Des Moines, Iowa, will

be installed as president for the ensuing year. The meeting will be concluded with the presentation of a medal to the retiring president, Dr. Lewis, by Dr. J. H. J. Upham, chairman of the Board of Trustees.

All meetings which are an official part of the session will be held in the Cleveland Public Auditorium, located in the heart of downtown Cleveland, with the exception of meetings of the House of Delegates, which will be held at Hotel Statler. The auditorium also will house the Registration Headquarters and the scientific and commercial exhibits.

MANY OHIOANS OF SCIENTIFIC PROGRAM

Ohio, as usual, will be well represented on the scientific program. The following will appear on the program as essayists or discussants:

George M. Curtis, Columbus; Alfred Friedlander, Cincinnati, Carl J. Wiggers, Cleveland, Henry J. John, Cleveland, Russell L. Haden, Cleveland, R. Wesley Scott, Cleveland, Claude S. Beck, Cleveland, Joseph T. Wearn, Cleveland, George W. Crile, Cleveland, Thomas E. Jones, Cleveland, J. I. Hofbauer, Cincinnati, John E. L. Keyes, Youngstown, Albert L. Brown, Cincinnati, Howard V. Dutrow, Dayton, Edward King, Cincinnati, Henry J. Gerstenberger, Cleveland, A. J. Horesh, Cleveland, J. D. Nourse, Cleveland, A. L. Van Horn, Cleveland, A. Graeme Mitchell, Cincinnati, Hugh J. Leslie, Cleveland, J. Victor Greenebaum, Cincinnati, Albert J. Bell, Cincinnati, C. W. Wyckoff, Cleveland, J. W. Epstein, Cleveland, Arthur G. Helmick, Columbus, J. A. Doull, Cleveland, John A. Toomey, Cleveland, Wallace S. Duncan, Cleveland, A. Carlton Ernstene, Cleveland, Charles A. Doan, Columbus, Gerald S. Shibley, Cleveland, E. P. McCullagh, Cleveland, Torald Sollmann, Cleveland, B. K. Wiseman, Columbus, Leon Schiff, Cincinnati, W. James Gardner, Cleveland, John Paul Wuigley, Cleveland, Alan D. Finlayson, Cleveland, Robert A. Kehoe, Cincinnati, P. A. Davis, Akron, W. N. Taylor, Columbus, E. O. Smith, Cincinnati, William Rosenberg, Cleveland, William E. Lower, Cleveland, C. J. McDevitt, Cincinnati, Charles C. Higgins, Cleveland, William H. Engel, Cleveland, J. S. Lewis, Jr., Youngstown, Thomas P. Shupe, Cleveland, Harry R. Trattner, Cleveland, Gordon F. McKim, Cincinnati, H. R. Conn, Akron, C. H. Heyman, Cleveland, Theodore A. Willis, Cleveland, J. J. Kurlander, Cleveland, Burt G. Chollet, Toledo, Walter G. Stern, Cleveland, L. E. Papurt, Cleveland, Joseph A. Freiberg, Cincinnati, Samuel L. Robbins, Cleveland, C. G. Barber, Cleveland, James A. Dickson, Cleveland, Eslie Asbury, Cincinnati, J. A. Caldwell, Cincinnati, Maxwell Harbin, Cleveland, G. I. Bauman, Cleveland, E. W. Shank, Dayton, M. A. Blankenhorn, Cleveland, V. C. Rowland, Cleveland, Edgar C. Baker, Youngstown.

Three Ohio physicians as officers of their respective scientific sections, have played a major part in arranging the programs to be presented by their sections. They are: Dr. C. W. Burhans, Lakewood, vice chairman of the Section on Pediatrics; Dr. Russell L. Haden, Cleveland, secretary of the Section on Pharmacology and Therapeutics, and Dr. John T. Murphy, Toledo, secretary of the Section on Radiology.

EXCELLENT SCIENTIFIC EXHIBIT ARRANGED

A number of Ohio physicians will have displays at the Scientific Exhibit, one of the outstanding features of the session. Incidentally in connection with the Scientific Exhibit, there will be a number of special demonstrations, including one in pathology presented under the direction of Dr. B. S. Kline, Cleveland, and an advisory committee of which Dr. Howard T. Karsner, Cleveland, is a member. Demonstrations will be conducted under the personal supervision of the following Cleveland physicians: Drs. Kline, Karsner, Harry Goldblatt, Allen Graham, R. Dominguez, Alan R. Moritz, H. S. Reichle, Anna M. Young.

The following Ohioans have entered scientific exhibits: Drs. Carl R. Steinke, Clarence L. Hyde and Associates, Akron; Claude S. Beck, Cleveland, Arthur H. Bill, Cleveland, William H. Weir, Cleveland, John E. L. Keyes, Cleveland, Myron Metzenbaum, Cleveland, William V. Mullin, Cleveland, W. L. Deeton, Cleveland, Franklin J. Bacon, Cleveland, O. W. Barlow, Cleveland, J. L. Jones, Cleveland, G. H. Gerlach, Cleveland, E. J. Stanton, Cleveland, W. E. Lower, Cleveland, E. L. Walsh, Cleveland, D. Roy McCullagh, Cleveland, Torald Sollmann, Cleveland, H. N. Cole, Cleveland, N. E. Schreiber, Cleveland, K. I. Henderson, Cleveland, Russell L. Haden, Cleveland, Alan R. Moritz, Cleveland, Victor C. Myers, Cleveland, E. Muntwyler, Cleveland, F. C. Bing, Cleveland, R. F. Hanzel, Cleveland, C. T. Way, Cleveland, H. S. Reichle, Cleveland, Howard T. Karsner, Cleveland, Thomas T. Frost, Cleveland, Wallace B. Hamby, Cleveland, W. James Gardner, Cleveland, Harry D. Piercy, Cleveland, Louis J. Karnosh, Cleveland, J. R. Driver, Cleveland, Lawrence N. Atlas, Cleveland, Charles A. Bowers, Cleveland, Charles C. Higgins, Cleveland, Thomas E. Jones, Cleveland, Samuel Brown, Cincinnati, H. Kennon Dunham, Cincinnati, John S. Lewis, Jr., Youngstown, Edgar C. Baker, Youngstown, J. C. Placak, Cleveland, N. W. Ingalls, Cleveland, Carl C. Francis, Cleveland, T. Wingate Todd, Cleveland, Harry C. Rosenberger, Cleveland, B. H. Broadbent, Cleveland, Oscar Turner, Cleveland, Y. A. Venar, Cleveland, W. M. Krogman, Cleveland, W. B. Seymour, Jr., Cleveland, Elmer F. Gooel, Cleveland, Theodore A. Willis, Cleveland, L. Dewey Anderson, Cleveland, Marion N. Gibbons, Cleve-

land, W. Kuenzel, Cleveland, C. Glenn Barber, Cleveland, Theodore T. Zuck, Cleveland, H. C. Moloy, Cleveland, W. E. Caldwell, Cleveland, John P. Gardiner, Cleveland, Francis Bayless, Cleveland, D. M. Glover, Cleveland, A. F. Sydow, Cleveland, R. H. Nichols, Cleveland, E. L. Shiflett, Cleveland, R. S. Dinsmore, Cleveland, E. Perry McCullagh, Cleveland, A. C. Ernstene, Cleveland, U. V. Portman, Cleveland, A. D. Ruedemann, Cleveland, and George W. Crile, Cleveland.

The following Ohio physicians served on the section exhibit committees which arranged for exhibits to be shown by their respective sections: Dr. A. D. Ruedemann, Cleveland, ophthalmology; Dr. William V. Mullin, Cleveland, laryngology, otology and rhinology; Dr. W. C. Fargo, Cleveland, pediatrics; Dr. Russell L. Haden, Cleveland, and Dr. A. Carlton Ernstene, Cleveland, pharmacology and therapeutics; Dr. John E. Rauschkolb, Cleveland, dermatology and syphilology; Dr. Paul A. Davis, Akron, preventive and industrial medicine; Dr. V. C. Rowland, Cleveland, gastro-enterology and proctology; Dr. C. E. Hufford, Toledo, and Dr. E. P. McNamee, Cleveland, radiology.

Among the special entertainment features of the Cleveland session will be the President's Reception and Ball to be held Thursday evening, June 14, at Hotel Cleveland; the annual touarament of the American Medical Golfing Association on Monday, June 11, at the Mayfield Country Club; smoker and buffet supper for medical veterans of the World War by the Cleveland Medical Veterans Society, Wednesday evening, June 13 at Hotel Statler, and innumerable luncheons and dinners by alumni and fraternity groups.

ENTERTAINMENT FOR WOMEN GUESTS

An exceptionally fine program of entertainment for women guests has been arranged under the direction of Mrs. Clyde L. Cummer, general chairman of the sub-committee on women's entertainment, and Mrs. Howard T. Karsner, chairman of the sub-committee on hospitality. The Hotel Carter will be headquarters for the women's activities. Among others, the following events have been arranged:

Tuesday, June 12, luncheon and bridge party at the Lake Shore Hotel, with a style show given by the Little Shop of the William Taylor Son and Company, followed by a motor trip along the lake front.

Wednesday, June 13, 8:15 p.m., complimentary musicale for visiting physicians and their wives at the Allen Memorial Medical Library by artists of the Cleveland Institute of Music, followed by an informal reception.

Thursday, June 14, noon luncheon at The Country Club and style show; trip through Halle Brothers Company store and visit to the beautiful gardens of Mr. and Mrs. Francis Fleury Prentiss. Evening, "Bring Your Husband Dinner", Hotel Carter.

Friday, June 15, golf tournament at Westwood Country Club.

Women guests desiring to attend any of the events on the program of women's entertainment should secure tickets *in advance* for them. The capacity at all the gatherings and events will be limited. Those who postpone the purchase of tickets until the last minute may be disappointed. Also, it is imperative that the committee in charge of the entertainment features know in advance the approximate number who will attend. It cannot be expected to underwrite these events unless it has some idea through the advance sale of tickets how many to expect in attendance and the hotels and clubs will not be able to take care of guests who decide to attend at the last moment or without advance reservation. After the number of guests prepared for by the hotels and clubs has been reached, no additional guests will be admitted, making it imperative that tickets be purchased well in advance of each event.

RAILROAD RATES, HOTELS, ETC.

Special railroad rates have been granted for the benefit of members of the American Medical Association and dependent members of their families who will attend the Cleveland meeting.

A rate of one and one-third fares for the trip to Cleveland and return will be allowed by the various carriers. To have the benefit of a return rate of one-third the regular fare, each member should obtain a certificate from the railroad ticket agent when he purchases his ticket to Cleveland. This certificate must be certified to by the Secretary of the A.M.A. at Cleveland and validated by a railroad representative there. When certified and validated, the certificate will entitle the holder to purchase a return ticket at one-third fare.

The Registration Bureau will be located in the Cleveland Public Auditorium. Only Fellows of the A.M.A., affiliate, associate and honorary Fellows and invited guests may register and take part in the work of the scientific assembly or attend the Scientific Exhibit. Physicians registering should present their pocket Fellowship cards. General officers of the A.M.A. and members of the House of Delegates will be registered at a special booth near the ballroom at the Hotel Statler.

The number of reservations made to date at Cleveland hotels indicates a record-breaking attendance. Therefore, those expecting to attend the meeting who have not made hotel reservations are urged to do so immediately to insure the type of accommodations desired. Requests for

hotel accommodations should be sent to Dr. Hubert C. King, chairman of the sub-committee on Hotels, 1604 Terminal Tower, Cleveland. A complete list of Cleveland hotels, with a description of accommodations offered and the rates, will be found on page 93 of the Advertising Section of the May 12 issue of *The Journal, A.M.A.*

— OSMJ —

Eight Events Carded for A.M.A. Golf Tournament, June 11

Eight events, carrying 50 prizes, will be played in the 20th annual tournament of the American Medical Golfing Association, to be held at the Mayfield Country Club, Cleveland, Monday, June 11, the opening day of the Annual Session of the American Medical Association in that city.

The principal event of the tournament is the championship flight, the prize for which is the Will Walter Trophy awarded for the low gross for 36 holes. Other events and trophies include: Association Handicap, 36 holes net, Detroit Trophy; Choice Score Championship, 36 holes gross, St. Louis Trophy; 18 Hole Gross Championship, Golden State Trophy; 18 Hole Handicap Championship, Ben Thomas Trophy; Maturity Event, Minneapolis Trophy; "Oldguard" Championship, Wendell Phillips Trophy, and Kicker's Handicap, Wisconsin Trophy.

All male Fellows of the American Medical Association are eligible to membership in the golfing association. An application blank for membership may be obtained from Bill Burns, executive secretary of the golfing organization, 4421 Woodward Avenue, Detroit. The membership of the organization is approximately 1100. Officers are: President, Dr. Homer Nicholl, Chicago; and vice presidents, Dr. Charles Lukens, Toledo, and Dr. John W. Powers, Milwaukee.

— OSMJ —

A dinner and smoker for the medical alumni of the University of Pennsylvania will be held on the evening of June 13 at the Carter Hotel, Cleveland, during the annual session of the American Medical Association in that city. Dr. J. M. Hayman, Jr., University Hospitals, Cleveland, is in charge of arrangements for the function.

— OSMJ —

A book, "Contagious Diseases", has been written by Dr. W. W. Bauer, director of the Bureau of Health and Public Instruction, American Medical Association and published by Alfred A. Knopf, New York City, in which Dr. Bauer presents information of particular interest to parents, emphasizing particularly the importance of prompt attention from the physician in all cases of communicable disease. The price per copy is $2.00.

O. S. U. Medical Alumni Reunion

During the A. M. A. Annual Session in Cleveland the week of June 11, the alumni of the College of Medicine, Ohio State University, will hold a reunion dinner on Wednesday, June 13, at 6:30 P. M. in the assembly room, Hollenden Hotel, at $1.50 per plate.

Dr. J. H. J. Upham, dean of the Medical College, will preside. Motion pictures of last year's Ohio State—Michigan and Ohio State—Illinois football games will be shown, with comments by Assistant Coach Ernie Godfrey. Other speakers will be William N. King, Cleveland, president, and J. B. Fullen, secretary, of the Ohio State University Alumni Association.

Details of the dinner are in charge of a committee headed by Dr. Russell J. Means, chairman, Columbus.

Reservations should be made on arrival in Cleveland at the Cleveland Academy of Medicine information desk in the Public Auditorium where all sessions of the A. M. A. will be held.

— OSMJ —

New York Graduate Fortnight

The Seventh Annual Graduate Fortnight of The New York Academy of Medicine will be devoted to a consideration of gastrointestinal diseases. The Fortnight will be held October 22 to November 2.

Sixteen important hospitals of the city will present coordinated afternoon clinics and clinical demonstrations. At the evening meetings prominent clinicians from various parts of the country who are recognized authorities in their special lines of work will discuss the various aspects of the general subject.

A comprehensive exhibit of anatomical, bacteriological and pathological specimens and research material will be shown. Many of the exhibits will be demonstrated.

— OSMJ —

Thirty-Fifth Annual Meeting of the American Proctologic Society will be held in Cleveland, Monday and Tuesday, June 11 and 12, with headquarters at the Hotel Cleveland. The first session of the meeting will be at 9 a. m., June 11, followed by a luncheon. The second session will begin at 1:30 p. m., followed in the evening by an executive meeting. The third session will be at 9 a. m. on June 12, followed by a luncheon. A clinic at the Cleveland Clinic Hospital will be held that afternoon. The annual dinner will be at the University Club that evening. The society will be welcomed to Cleveland by Dr. C. L. Cummer, president of the Ohio State Medical Association, and David S. Ingalls, director of public welfare, Cleveland.

RECENT LEGISLATIVE ACTIVITIES ≠≠≠ TAXATION WORKMEN'S COMPENSATION, FINANCES, AND PROBABLE FUTURE PROBLEMS

Financial problems of many political subdivisions and school districts of the state resulting from decreased revenues due to the reduction of the constitutional limitation on the real estate tax from 15 to 10 mills were still unsolved on May 4 when, by executive order, Governor White prorogued the Ohio General Assembly until November 19.

Action of the Governor in adjourning the Legislature, which had been in special session since December 6, was taken by him after leaders of the Assembly and the Governor's advisors were convinced that it was practically impossible at that time for the Legislature to arrive at any agreement on a taxation program that would meet the financial situation of the political subdivisions and the schools.

Although the majority of the membership of the General Assembly were agreed that new sources of revenue to meet the deficits anticipated by the cities, counties and school districts must be found to support the schools and maintain the essential functions of local government, even should drastic economy measures be put into effect, numerous differences of opinion as to what replacement taxes should be levied to meet this situation prevented the General Assembly from evolving a taxation program and ultimately threw it into a deadlock which precluded constructive accomplishment.

Almost every kind of taxation measure conceivable was introduced. All but one revenue-raising proposal were defeated by at least one branch of the General Assembly. The one exception was the measure re-enacting the special taxes on cosmetics and admissions to raise between $8,000,000 and $9,000,000 for poor relief purposes.

WORKMEN'S COMPENSATION MEASURE ENACTED

When the Legislature will be called upon to again take up taxation and revenue legislation is problematical. Some observers are of the opinion these questions will not come before the General Assembly again before next November 19 when the governor's adjournment order expires and when, should the assembly convene, all measures still pending may be considered. Others believe the Governor may in special messages ask the Legislature to take up the taxation problem before that time, possibly at another special session he is anticipating calling in June for the enactment of amendments to the banking and building and loan statutes.

One of the major pieces of legislation enacted by the Legislature at its second special session which began December 6 was the measure (House Bill No. 110) transferring jurisdiction over the employes of the State Industrial Commission back to the Commission. This measure was passed with an emergency clause and became effective May 5 upon being signed by the Governor.

As pointed out in the May, 1934, issue of *The Journal*, pages 318-320, this legislation was prepared in accordance with recommendations made by the Governor's Investigating Committee on Workmen's Compensation in a preliminary and partial report submitted to Governor White late in March.

The measure amends the Administrative Code which was enacted in 1921 and which then placed the jurisdiction of the Director of Industrial Relations all employes of the Division of Workmen's Compensation. It authorizes the transfer of the personnel of the Division of Workmen's Compensation to the jurisdiction of the Industrial Commission and grants the commission the power it had previous to 1921, to select, make changes and direct the activities of all employes engaged in work that is a part of the administration of the Workmen's Compensation Law.

NO ADDITIONAL FUNDS PROVIDED

As originally drafted and presented to the General Assembly, the bill sought to remove from the classified civil service some of the personnel of the Division of Workmen's Compensation, such as physicians, attorneys, referees, payroll inspectors, chief auditors, etc., and would have permitted the Commission to appoint or designate attorneys to represent the Commission in investigations and litigation.

However, these provisions were stricken from the measure before its enactment by amendments in committee and on the floor because of objections on the part of many members of the Assembly to transferring such employes to the unclassified civil service and because of protests made by the Attorney General to the policy of granting boards and commissions the power to hire or appoint attorneys to represent it in matters which at present are handled by employes of the Attorney General's Department.

A companion measure appropriating $125,000 to be used by the Commission in employing additional personnel for several of the undermanned departments of the Division of Workmen's Com-

pensation did not reach a vote before the General Assembly was adjourned.

As pointed out by the Governor's investigating committee in recommending legislation of this nature, the act transferring employes to their former relationship with the Industrial Commission centralizes responsibility of administration, creates the necessary powers for thorough and business-like administration of the Compensation Law, and should result in the gradual elimination of delays and inefficiency in handling workmen's compensation claims, payroll audits, fee bills, etc.

A number of appropriation measures were enacted at the special session, including $3,000,000 as the state's share of a state-federal building program for state welfare institutions; $3,000,000 to finance old age pensions; and $2,000,000 as the state's share in the state-federal Muskingum conservancy district flood control program. It is doubtful if money will be available to meet all of this aggregate $8,000,000 appropriation since no new revenue-producing measures were enacted. A number of measures enacted permit municipalities and school districts to borrow money and issue notes for a limited time to tide them over the present financial situation until a permanent taxation program can be enacted.

LIQUOR BILL STILL PENDING

Among the measures left pending when the General Assembly quit was the Mosier bill (Senate Bill No. 43) amending various sections of the Liquor Control Act enacted last December, providing for the state monopoly system for the sale of intoxicating liquor. In all probability this, or a similar measure, will be considered at some future date by the Legislature inasmuch as changes in the present Liquor Control Act are considered necessary to clarify certain provisions of the liquor statutes.

The present Liquor Control Act permits the prescribing of medicinal liquor or alcohol by physicians and the administration and dispensing of medicinal liquor or alcohol by physicians in the course of his practice. It provides that liquor or alcohol prescribed by a physician or used by him in his practice may be sold by a druggist holding a G Permit.

Amendments proposed in the Mosier bill would have permitted holders of a G Permit to sell liquor or alcohol on prescription with no limitation on the number of prescriptions but a one-quart limitation on the quantity sold on each prescription. It would have prohibited G Permit holders (druggists) from selling medicinal liquor to physicians for use in their practice, making it necessary for physicians to obtain such liquor supplies from a state liquor store. Under the changes proposed by the Mosier bill, physicians would have the choice of purchasing alcohol for use in their practice from druggists or direct from a manufacturer or distributor of alcohol, licensed to sell alcohol to physicians, druggists, dentists, hospitals, etc., under a J Permit.

— OSMJ —

Recent Supreme Court Decision Regarding Malpractice

An interesting decision in a suit for damages following personal injuries and involving an action for alleged malpractice on the part of a physician was handed down recently by the Ohio Supreme Court (Tanner v. Espey, No. 24233).

The principal points of the case are summarized in the following syllabus of the decision:

1. If one who has suffered personal injuries by reason of another's negligence exercises reasonable care in obtaining the services of a competent physician or surgeon, and such injuries are thereafter aggravated by the negligence, mistake or lack of skill of such physician or surgeon, such aggravation is a proximate result of the negligence of the original tort-feasor, and he is liable therefor.

2. If one has suffered personal injuries which thereafter were aggravated by the malpractice of an attending physician or surgeon, and then executes a valid general and unconditional release to the original tort-feasor, in full settlement for all present and future claims and causes of action, such release operates as a bar to an action against such physician or surgeon for such malpractice.

In this case the plaintiff in error was injured in an automobile accident. She received from the automobile owner a sum of money in full settlement of the claim against him, executing in turn an unconditional release in exchange for the compensation received.

Subsequently the plaintiff in error filed suit against the defendant in error charging aggravation of her injuries through alleged malpractice on the part of the defendant in error. The common pleas court rendered judgment in favor of the defendant physician. The judgment of the trial court was affirmed by the appellate court and the judgment of the latter court was affirmed by the Supreme Court.

The Supreme Court in its decision upheld the fundamental rule that but one satisfaction can be executed for the same demand. It emphasized that the person guilty of negligence in the first instance was liable for all the plaintiff's injuries including the aggravation thereof. Moreover, it held that since the plaintiff saw fit to release this person in full from all claims and causes of action in consideration of the payment of a specified sum of money, the plaintiff considered her total damages to be that sum and therefore cannot recover additional damages from the physician.

LATEST DEVELOPMENTS ON MEDICAL CARE UNDER F.E.R.A., REGULATIONS ON WORK DIVISION INJURIES LOCAL DELAYS AND OTHER PROBLEMS

Supplemental instructions to county relief directors and physicians relative to the procedure that should be followed in making out reports and fee bills in connection with injuries to persons employed on projects under the Works Division, F.E.R.A., have been issued by the Department of Safety, State Relief Commission.

As pointed out in the May issue of *The Journal*, pages 314-317, those injured on projects under the Works Division of the State Relief Commission will be provided with medical and hospital care at the expense of the State Relief Commission. In that article, there appeared a complete summary of the procedure to be followed in injury cases; what forms should be used; fees paid, etc.

The following supplemental instructions have been issued by the State Relief Commission to county relief directors, who have been advised to transmit them to all physicians who have signed up to render service to injured Works Division employes:

1. Duplicate signed copies of the injury report, Form (FB-1), as well as the medical report, Form (FB-1, are required for all F.E.R.A. injury cases requiring medical attention as instructed in "Injury Procedure" issued April 14, 1934.

2. Forms (FB-1) should be completed by the attending physician and returned to the county director as soon as possible, to expedite the payment of medical fees.

3. Supplementary (FB-1) forms shall be issued by the county director where the medical treatment of an injury involves more items than can be entered on a (FB-1) form.

4. The initial (FB-1) forms, accompanied by the signed (IR-1) forms, in duplicate, shall be forwarded to the Department of Safety immediately upon receipt.

5. Each supplementary (FB-1) form shall be accompanied by a written statement from the attending physician as to the physical status of the injured employe.

6. Attention is called to the Fee Schedule incorporated in "Injury Medical Procedure". Minor injuries are construed as those which do not involve surgery, orthopedics, or anesthesia. The current fees allowed by the Industrial Commission of Ohio are 20 per cent less than those appearing in the printed general and special fee schedule of the Commission. These current rates are applicable in F.E.R.A. cases not classified as minor injuries.

7. Do not use forms (RM) and (RO) in connection with the medical treatment and care of employes injured on F.E.R.A. Works Division projects. Such cases require the use of forms (IR-1) and (FB-1) which are to be sent to the Department of Safety upon completion.

In this connection, it will be remembered, as pointed out in the May issue of *The Journal*, that for treating minor injuries received by Works Division employes, physicians will be paid fees allowed under the fee schedule for "Medical Care Provided in the Home to Recipients of Unemployment Relief" found in Supplement No. 1 (Revised) to Rules and Regulations No. 7 of the Federal Emergency Relief Administration. (See April, 1934 issue, *The Journal*, page 242). For treating injury cases requiring special medical or surgical care and not classified as minor injuries, physicians will be paid in accordance with the current General and Special Fee Schedule of the State Industrial Commission.

REGULATIONS ON HOSPITALIZATION ISSUED

Under date of May 14, the State Relief Commission forwarded to each county relief director a Revised Hospital Contract to be executed in triplicate by the county commissioners of each county, as administrators of funds of the Works Division, State Relief Commission, with each hospital in the respective county which desires to accept injured Works Division employes for hospitalization.

This contract is to be used in instances where contracts for the hospital care of indigents are not sufficiently broad in scope to include Works Division injury cases.

All hospital contracts must be approved by the State Relief Commission before payment can be made by the Commission for services rendered by the hospital and "the patient-day rates of such contracts should not be in excess of those ordinarily charged the county for the care of indigent persons".

The rules and regulations governing hospital contracts became effective April 1, 1934, and each contract shall terminate on January 1, 1935.

Following are the principal provisions of the contract which hospitals desiring to accept Works Division injury cases must negotiate with the

county commissioners of the county in which the hospital is located:

The County Commissioners agree to pay to this institution the patient-day cost as herein outlined for such attention rendered individuals protected under the procedure of the State Relief Commission of Ohio, relating to the care of employes injured on Work Projects under F.E.R.A., and recognized by the State Relief Commission as a legitimate expense to be paid by it.

It is mutually agreed that this patient-day rate shall be construed as covering the services listed below: (Services not included must be cancelled).

Room and Board, Operating Room, Anesthesia, *X*-ray, Regular Nursing, Resident Staff, Physiotherapy, Laboratory, Emergency, Medication, Dressings, Special Nurse's Board.

The hospital further agrees that it will accept the opinion of the physician in charge of the patient as to the need for individual room service and will furnish such service when ordered.

The hospital further agrees that if an employe, protected as above, pays his own bill for hospital services, he shall not be charged a rate in excess of that specified in this contract. If any such excess has been charged and paid before it is known that the injured man is a protected F.E.R.A. employe, such employe shall be entitled to a refund from the hospital equal to the overpayment, or such part thereof as the State Relief Commission may deem justifiable after consideration of all facts in each individual case.

The hospital agrees that it will, upon request from the State Relief Commission, furnish a certified copy of the hospital record of any industrial patient covered by this contract.

CHIEF PROVISIONS SUMMARIZED

The following rules and regulations shall govern the interpretation of this contract:

1. (a) A HOSPITAL PATIENT—An individual appearing on the record as an admitted patient but will not include patients applying for after-care following discharge from a hospital or from the care of a physician.

(b) UNIT CENSUS PERIOD—24 hours from midnight of one night to midnight of the next.

(c) PATIENT DAY—Appearance on the census or treatment rendered entirely within a unit census period.

(d) PRIVATE ROOM—A room containing not more than one patient's bed.

(e) SEMI-PRIVATE WARD—A room containing more than one patient's bed but not more than four patients' beds.

(f) WARD—A room containing more than four patients' beds.

(g) EMERGENCY CASE—Any case which requires and applies for treatment within twenty-four hours after the accident and which has not had previous treatment by a physician.

2. The County Commissioners will enter into formal contract with each hospital for each calendar year for the care of State Relief Commission cases.

3. The number of days treatment for which compensation may be claimed for a compensable case shall be equal to the number of times the patient appears upon the hospital census, provided that one day may be charged for patients both admitted and discharged within the twenty-four hour census period.

4. Claim for addition to actual operating services will be considered only when a detailed statement of service for which claim is made is submitted to the State Relief Commission.

5. The cost of all professional, scientific and ordinary services and supplies incident to the diagnosis, care and treatment of patients while in the hospital, as shown above, except attending physician's and special nurse's fees shall be included in the patient-day rate.

6. Any claim for compensation for professional, scientific, or ordinary service rendered a State Relief Commission patient which does not appear in the hospital accounts as a bona fide transaction between the hospital and the patient, shall not appear in the hospital statement as a claim for compensation. Such claim shall be made in a separate statement by the party rendering the service. This shall not be construed to include individuals referred to a hospital solely for *X*-ray or laboratory service.

7. A statement presented by any hospital to the County Commissioners claiming compensation for services rendered shall specify:

(a) Date of entrance and date of discharge.
(b) Total number of days treatment.
(c) Name of attending physician.
(d) The total amount due for services rendered.
(e) The amount received from any other source for services rendered the same patient during the same period.
(f) The source of any payment received by the hospital in addition to that allowed by the State Relief Commission.
(g) A short history of the case as shown by the hospital record.

A statement shall be rendered for each case admitted. The character of service with respect to room or ward shall be that specified by the physician in charge of the case.

8. The contract between the hospital and the County Commissioners shall state definitely what services are included in the patient-day rate of the hospital.

9. Whenever a hospital shall neglect or refuse to enter into a contract on the above basis with the Board of County Commissioners of the county in which the hospital is located, compensation shall be made such hospital on a flat rate of not to exceed $3.00 per day, no extra charges being accepted.

10. EMERGENCY ROOM FEE SCHEDULE:

Removal of foreign body from cornea—$2.00.

Administration of antitetanic serum (prophylactic)—$3.00.

Simple dressing, approximation of wounds with clips or sutures, reduction of fracture without anesthetic and other services of comparable nature—one-half per diem contract rate.

Burn cases with extensive dressings and cases requiring anesthetic—per diem contract rate.

These fees are applicable only in cases coming within the class of emergency cases as defined in paragraph (g) of Rule 1 and it is understood that all such services are to be given by a licensed physician or under his personal supervision.

11. The State Relief Commission reserves the right to make any amendment to these rules and regulations without notice, provided that such amendment does not involve abrogation of contract.

A number of additional and supplemental instructions have been issued by the State Relief Commission relative to the procedure to be fol-

lowed in providing medical care in the home to recipients of unemployment relief under Supplement No. 1 (Revised) to Rules and Regulations No. 7 of the Federal Emergency Relief Administration and in accordance with the Revised Medical Fee Schedule announced by the Commission on March 17 and effective April 1. (April, 1934, issue *The Journal*, page 242).

Following are the principal supplemental instructions submitted to county relief directors regarding the medical program:

1. Relief funds provided for medical care in the home cannot be used to carry on the work of clinics such as dental, eye and prenatal. The purchase of spectacles may be authorized by the relief director only in cases of emergency, and on the advice of an oculist.

2. Physicians and dentists shall signify their willingness to render medical or dental service to families receiving emergency relief by signing an agreement (Form MA or DA) with the County Emergency Relief Administration.

3. The physician attending an obstetrical case is to be guided by his own judgment in determining the number of visits to be made. However, mileage allowance for uncomplicated cases shall be limited to that of two trips.

4. Fees for services not found in the fee schedule for ordinary office and house visits or in the current fee schedule of the State Industrial Commission shall be established by agreement between the local relief director and the local medical, dental and nursing organizations.

NO ACTION ON ADVISORY COMMITTEE

No action has been taken by the State Relief Commission at the time this was written to put into effect a plan under consideration by it for having established in each county a local medical advisory committee, as contemplated in Federal Rules and Regulations No. 7, to advise and cooperate with the county relief director in administrative details in connection with medical and public health aspects of the county's poor relief program. (See May issue, *The Journal*, page 315).

Officers and committees of the State Association have made insistent requests to state relief officials that instructions be issued to county relief directors to invite local medical societies to formulate such medical advisory committees, pointing out that such committees would be able to assist local relief directors in administrative details and serve in an advisory capacity, especially in instances where professional judgment is required and indispensable.

In some counties, the relief director has requested and received the cooperation and assistance of the county medical society in administration of the medical relief program. In others, no such effort has been made and the local medical society has not been consulted on medical phases of the county relief program.

PAYMENT OF PHYSICIANS DELAYED

Payment of physicians for medical services to indigents has been slow in some counties. In some instances medical bills are not being paid in full and are several months overdue. In other counties, especially those where the relief director realizes the importance of adequate medical care and appreciates the services rendered by the medical profession, physicians are being paid promptly in accordance with the increased medical fee schedule effective April 1. Some county relief directors have been using funds allocated for medical services for other types of direct relief and in many counties the funds allocated for medical services have been woefully inadequate to meet the needs of the large number of families on the relief rolls. Several counties have not established a medical program for those on the relief rolls principally because, in the opinion of the local relief director, funds allotted to the county have been required to meet other relief needs. Funds for medical services in some counties have not been made available due to failure on the part of county officials to issue special poor relief bonds. Payment of medical bills has been left in some instances to the various townships within the county, most of whom are without sufficient funds to carry on their usual routine activities.

CONCERTED LOCAL ACTIVITY ESSENTIAL

In one or two counties, some physicians have failed to submit their fee bills promptly to the county relief administration, causing unnecessary delay in the payment of medical bills. Some physicians have failed to follow instructions regarding reports, etc., and have not followed the fee schedule in making out their fee bills. This has added to administrative confustion and has occasioned delay in the payment of medical bills.

These and other difficulties in connection with medical care for the needy are questions that should be taken up by representatives of each county medical society with their respective county relief director. Some of them may be solved through proper contacts with the relief director and through concerted demands that funds authorized by the State Relief Commission for medical services be used for that purpose and that physicians' fee bills be paid promptly.

C. W. A. BILLS TO BE PAID EVENTUALLY

Considerable delay has been reported in the payment of physicians for services rendered persons injured on projects carried on under the former Civil Works Administration program, which was abandoned in favor of the present part time Works Division program. Many physicians have not been paid for several months for ser-

vices rendered C.W.A. workers and some have never received payment for such services.

The payment of physicians for services to disabled C.W.A. workers is a duty delegated by law to the United States Employes' Compensation Commission. That Commission was organized 17 years ago to handle compensation and medical claims of regular employes of the Federal Government. When the task of dealing with some 4,000,000 additional persons under the C.W.A. program was placed upon this Commission, its auditing force was not sufficient to handle the additional work promptly and efficiently.

Moreover, the Employes' Compensation Commission had no funds to meet the claims of C.W.A. employes and bills of physicians for services to them until February 15. By that date there was a large accumulation of claims and fee bills, many of them dating back to November and December of 1933. In all, about 100,000 claims, half of which are physicians' bills, have been filed with the Commission.

Within the past month, the auditing force of the Employes' Compensation Commission has been increased and claims before the Commission are now being audited and completed at the rate of about 3000 a week. All claims and fee bills are being audited and paid in accordance with the dates of filing the claims. Assurance has been given that all physicians' bills submitted to the Commission for services under the C.W.A. program will be passed upon by the Commission and payment made, if authorized by the Commission as promptly as the limited personnel of the Commission can handle the work.

— OSMJ —

Dr. Upham Reappointed

Dr. J. H. J. Upham, Columbus, dean of the College of Medicine, Ohio State University, and chairman of the Board of Trustees, American Medical Association, has been reappointed by Governor White as a member of the State Medical Board to serve until 1941. This is his fourth consecutive appointment to the Board. He was first appointed to the Board twenty-one years ago, and has served several terms as chairman.

— OSMJ —

The Gynecean Hospital Institute of Gynecologic Research, University of Pennsylvania, is conducting an intensive study of families into which congenitally malformed individuals have been born. Those making the study are especially interested in families in which malformations have appeared in two or more children. Physicians who have knowledge of any such families are invited by the study committee to communicate with and submit data to Dr. Douglas P. Murphy, in care of the Gynecean Hospital Institute, University Pennsylvania, Philadelphia.

Annual Reunion of Cincinnati Alumni to Be on June 14

Plans are being completed for the 1934 reunion of the Alumni Association of the College of Medicine, University of Cincinnati, to be held on June 14. A high spot of the program will be the banquet to be at the Netherland Plaza. A golf tournament will be held and clinics presented.

Arrangements are being made under the general direction of Dr. William M. Doughty, president of the Alumni Association. The following committees are assisting him:

Speakers——Drs. Stanley E. Dorst, Richard S. Austin, Dudley W. Palmer, Cecil Striker and Robert A. Lyons.

Golf—Dr. Louis Feid, Jr.

Publicity—Drs. Carl W. Wilzbach, Frank B. Cross and Robert C. Rothenberg.

Clinics—Drs. Alfred Friedlander, Louis G. Hermann, Stanley E. Dorst, Robert A. Lyon and Robert C. Rothenberg.

Banquet—Drs. Fred W. Heinold, Robert H. Kotte, Helena T. Rattermann and Donald J. Lyle.

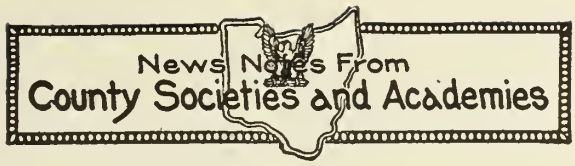
— OSMJ —

Licensed Through Reciprocity

The following have been granted licenses through reciprocity to practice medicine and surgery in Ohio by the State Medical Board: Emil Alvermann, Cleveland, St. Louis University; Joseph E. Brown, Cleveland, Leonard Medical College; Richard K. Dalrymple, Millersburg, University of Buffalo; Margaret P. H. Foulger, Cincinnati, University of Cincinnati; Wilbur R. Houston, Spencer, Eclectic Medical College, Cincinnati; Leabelle A. Isaac, Cleveland, Western Reserve University; Meyer S. Jolson, Cincinnati, University of Maryland; Joseph D. Landesman, Toledo, Detroit College of Medicine and Surgery; Bernard B. Larson, Cleveland, State University of Iowa; Samuel N. Maimon, Dayton, Vanderbilt University; Clement F. Neacy, Dayton, Rush Medical College; Kenneth A. Owen, Akron, Johns Hopkins University; Clare R. Rittershofer, Cincinnati, University of Michigan; Martin B. Taliak, Cleveland, University of Michigan; Gregory G. Floridis, Dayton, University of Michigan; Lewis C. Fritts, Akron, Jefferson Medical College; James S. Newton, Sandusky, State University of Iowa, and Norman J. Birkbeck, University of Wisconsin.

— OSMJ —

A revised edition of the leaflet, "Eye Protection in Industry" has been issued by the National Society for the Prevention of Blindness, 450 Seventh Avenue, New York.



First District

ACADEMY OF MEDICINE OF CINCINNATI
(Harold F. Downing, M.D., Secretary)

May 7—General Session. Program: "Various Aspects of Duodenal Ulcer", Dr. Henry Wald Bettmann and Dr. Louis Sommer; discussion by Dr. L. Howard Schriver; "Amebiosis: A Discussion of Three Fatal Cases Occurring in This Community, with Necropsy Findings and Lantern Slide Demonstration", Dr. K. V. Kitzmiller; discussion by Dr. Dudley W. Palmer and Dr. H. H. Shook.

May 14—General Session. Program: "Prolapse of the Kidney", Dr. Parke G. Smith; discussion by Dr. W. O. Ramey and Dr. Charles J. McDevitt; "Fungi", by Dr. H. L. Classen; discussion by Dr. E. B. Tauber, Dr. Samuel Goldblatt and Dr. Leon Goldman.

May 21—General Session. Program: "Indications and Limitations of Radium in the Treatment of Cancer", Dr. Max Cutler, Chicago.

May 28—Annual Outing at the Hyde Park Country Club.

Adams County Medical Society met on April 25 at West Union with a good attendance. The program was presented by Dr. J. E. Pirrung, Dr. W. D. Haines, and Dr. C. A. Koch, Cincinnati, and Dr. R. B. Ellison, Peebles.—News Clipping.

Butler County Medical Society held a thorough discussion of poor relief problems at its meeting May 2 at the Middletown Hospital. County Relief Director Tetlow explained the problems confronting the relief administration in the county. —Vernon Roden, M.D., secretary.

Clinton County Medical Society at its meeting May 1 was addressed by Dr. Henry Freiberg, Cincinnati, on "Prostatic Resection". The meeting, held at the Shreve Hotel, Wilmington, was well-attended.—News Clipping.

Warren County Medical Society met May 1 at Lebanon. The guest speaker was Dr. Leo S. Friedman, Cincinnati. He discussed "Communicable Diseases".—News Clipping.

Second District

Clark County Medical Society was addressed by Dr. Clement L. Jones at its luncheon meeting April 12 at the Hotel Bancroft, Springfield. Dr. Jones spoke on "Angina Pectoris". A round-table discussion followed the address.

At its meeting on April 26, the society was addressed by Dr. E. M. Huston, Dayton, councilor of the Second District. Dr. Huston discussed social, economic and governmental questions affecting medical practice.—News Clipping.

Greene County Medical Society had as its guest speaker on April 5, Dr. E. M. Huston, Dayton, councilor of the Second District, and Dr. A. O. Peters, health commissioner of Dayton. Both discussed poor relief problems.

On May 3, the society was addressed by Dr. Jerome Hartman and Dr. H. L. Brumbaugh. Dr. Hartman spoke on "Osteomyelitis" and Dr. Brumbaugh on "Orthopaedic Causes of Pain in the Back". Both used lantern slides to illustrate their talks.—Harold E. Ray, M.D., Secretary.

Miami County Medical Society held a chicken dinner meeting on May 4 at the Coates Inn, West Milton. After the dinner, the following program was presented: "Infections of the Upper Respiratory Tract", Dr. J. F. Hill; "Differential Diagnosis of Acute Appendicitis", Dr. H. W. Kendall, and "A Report on Throat Smears in Diagnosis of Scarlet Fever", Dr. E. R. Hiatt. At the business session, a discussion on the operations of the newly-formed Credit Bureau was held. It was reported that 6,186 names have been listed with the bureau from 26 physicians' offices and that to date, 4,150 collection letters have been supplied, many of which have been sent out with favorable results.—Bulletin.

Montgomery County Medical Society met in regular session May 4 at the Stillwater Sanatorium. Following dinner, Dr. John Skavlem, Cincinnati, the guest speaker discussed "Tuberculosis".

At its regular meeting, May 18, the society was addressed by Dr. A. O. Peters, city health commissioner of Dayton, on "The New Set-Up in Medicine From a Public Health Standpoint". Five-minute discussions on the following subjects were made by: Dr. Leo Schram on "Contagion"; Dr. W. A. Ricketts on "Pre-natal Care", and Dr. C. C. Payne on "Examination of School Children".—Bulletin.

Preble County Medical Society in session May 17 at the Seven Mile Tavern, Eaton, was addressed by Dr. Parke G. Smith, Cincinnati.—Bulletin.

Third District

Hancock County Medical Society held its regular meeting May 3 at the home of Dr. F. M. Wiseley, Findlay. Many out-of-town physicians were guests of Dr. Wiseley and the society. The guest speaker was Dr. W. G. McGaw, Cleveland, who presented a paper, illustrated with slides, on

"Common Disorders of the Feet".—H. O. Crosby, M.D., Secretary.

Hardin County Medical Society in session April 19 at the Kenton Cafe was addressed by Dr. Berman S. Dunham, Toledo, on "Infantile Paralysis".—News Clipping.

Logan County Medical Society held a dinner meeting May 4 at Hotel Ingalls, Bellefontaine. The guest speaker was Dr. C. A. Mills, Cincinnati, who spoke on "Climate and Weather As Health Factors". A general discussion followed the address.—News Clipping.

Marion County—Regular meeting of the Marion Academy of Medicine was held at the City Hospital, Marion, May 1. A program of special interest to general practitioners was presented. A case report was presented by Dr. B. B. Hurd, Marion. Dr. B. D. Osborn, Waldo, read a paper on "The History of Lithotomy". Dr. William N. Taylor, Columbus, the guest speaker, gave an interesting talk on "Abdominal Symptoms Due to Kidney Lesions".—J. W. Jolley, M.D., Secretary.

At a called meeting of the Academy on May 15, it was called upon to consider a proposal of the Marion County Relief Administration that a physical examination be made of the school children of Marion within one week for the purpose of comparing the physical condition of children from families on relief with the condition of children from families not on relief. The proposal provided that physicians should make such physical examinations without compensation. After a thorough consideration of the plan, the Academy disapproved the plan as proposed by the relief administration.—J. W. Jolley, M.D., Secretary.

Van Wert County Medical Society in session May 8 enjoyed a program on "Newer Aspects of Therapy" presented by Dr. O. E. Cress, Dr. C. A. Morgan and Dr. W. P. Clay.—Bulletin.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

May 4—General Session. Program: "The Significance of Iodine in the Management of Hyperthyroidism", Dr. George M. Curtis, Columbus.

May 11—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Value and Limitation of Radium Therapy", Dr. Harold W. Jaycox, Ann Arbor, Michigan.

May 18—Medical Section. Program: Symposium on Diseases Associated with Hemorrhagic States. "Clinical Considerations", Dr. L. A. Levison; "Laboratory Aids", Dr. T. L. Ramsey; "Blood Transfusion", Dr. W. W. Beck; discussants, Dr. S. R. Salzman and Dr. R. B. Tucker.

May 25—Surgical Section. Program: "Proctological Abscesses", Dr. Wendell W. Green; discussants, Dr. W. W. Stone; "Urological Abscesses", Dr. A. S. Avery; discussants, Dr. A. D. Vogelsang; "Gynecological Abscesses", Dr. T. C. Kiess; discussant, Dr. M. D. Haag.

Putnam County Medical Society met in regular session at the Dumont Hotel, Ottawa, on May 1. The essayists were Dr. Foster Myers and Dr. August Schade, both of Toledo. Dr. Myers discussed "Pernicious Anemia, Its Symptoms, Diagnosis and Treatment". Dr. Schade spoke on "The Pathology and Differential Diagnosis of Pernicious Anemia as Revealed in the Microscope". A general discussion followed the papers. The meeting was well-attended and much interest shown.—J. R. Echelbarger, M.D., Correspondent.

Sandusky County Medical Society held its April meeting on April 26 at the Masonic Club Rooms, Bellevue, with an excellent attendance. The guest speakers were Dr. Clayton C. Perry and Dr. John D. Osmond, both of Cleveland. The former spoke on "The Diffeffrential Diagnosis and Treatment of Diseases of the Colon and Rectum". Dr. Osmond discussed "The *X*-ray Diagnosis of Colon Diseases". Both papers were illustrated with lantern slides. Those present were urged to become Fellows of the American Medical Association to be eligible to attend the forthcoming meeting of the A.M.A. in Cleveland. —Charles J. Wehr, M.D., Secretary.

Wood County Medical Society was addressed on April 19 by Dr. Bernhard Steinberg and Dr. J. Lester Kobacker, both of Toledo. Dr. Steinberg spoke on "Pathology of the Heart, Lungs and Kidneys as Concerns the General Practitioner". Dr. Kobacker presented a paper on "Modern Clinical and Laboratory Features of Cardiac Diagnosis".—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(C. H. Heyman, M.D., Secretary)

May 4—Clinical and Pathological Section, Charity Hospital. Program: "Presentation of Dermatological Cases", Dr. C. L. Cummer; "Ulcers of the Leg", Dr. C. H. Verovitz; "Perforating Ulcer of the Posterior Stomach Wall—Presentation of Cases", Dr. F. C. Herrick; "Polycythemia, Two Cases After Five Years; Rheumatic Heart Disease with Filbrillation, Wuinidine Therapy", Dr. John P. Anderson; "Unusual Tumor of the Lymphoid System Associated with Congenital Cystic Lungs in An Infant of 15 Months", Dr. Paul Gross; "Pulmonary Blastomycosis", Dr. J. D. Osmond.

May 11—Joint meeting of the Experimental Medicine Section and the Cleveland Section of the Society for Experimental Biology and Medicine. Program:

"The Mechanism by Which Barbiturates In-

hibit Gastro-Intestinal Motility", K. R. Phelps and J. P. Quigley; "The Factors Involved in Gastric Inhibition from Ingested Fats and Carbohydrates", J. P. Quigley; "A Study of Monophasic Ventricular Action Currents Following Coronary Ligation", Dr. C. J. Wiggers and H. Wiggers; "Further Observations on the Systolic and Diastolic Coronary Flow by An Autoperfusion Method", Donald H. Gress; "The Impairment of Coronary Flow During Aortic Insufficiency", Dr. Harold Green; "Experimental Criteria of Improved Coronary Blood Flow with Observations on the Effect of Some Drugs", Dr. C. J. Wiggers and Dr. H. D. Green.

May 18—General Session. Program: "Some Causes of Nervous Indigestion", Dr. Walter C. Alvarez, Rochester, Minn.

May 22—Military Medicine Section. Program: "Scientific Progress in Leprosy", Dr. J. A. Doull.

May 23—Practice of Medicine Section. Program: "Certain Phases of Pellagra", Dr. Tom D. Spies; "Arthritis", Dr. R. M. Stecher.

Ashtabula County Medical Society held a dinner meeting April 17 at Ashtabula. The guest speaker was Dr. George Crile, Cleveland.—News Clipping.

The May meeting of the society was held May 8 at Maple Manor, Geneva-on-the-Lake. Following a dinner, a paper was read by Dr. H. A. Skeel, Cleveland, on "Hemorrhages of Late Pregnancy and Labor". A brief discussion was made by Dr. F. F. Jordan, Cleveland, and Dr. DeLee's film on "Science and Art of Obstetrics" was shown.—A. M. Mills, M.D., Secretary.

Lorain County Medical Society met in regular session May 8 at Elyria. A motion picture, "Low Forceps Delivery" was shown as Dr. D. Thomas lectured on the subject. Dr. George D. Nicholas led the discussion which followed.—Bulletin.

Sixth District

Ashland County Medical Society in session April 13 was addressed by Dr. James L. Reycraft, Cleveland, on "The Practice of Obstetrics —1934 Model". At the business meeting, the society discussed the revised medical fee schedule announced by the State Relief Commission. It was the sense of the society that members of the society could use their own judgment in the matter of signing the agreement for caring for indigents under the schedule.

At its meeting on May 11, the society was addressed by Dr. H. G. Beatty, Columbus, on "Sinus Infection in Children and Its Relation to Lower Respiratory Infections". It was an excellent paper and well received.—M. J. Thomas, M.D., Secretary.

Mahoning County Medical Society had as its guest speakers on May 15 at the Youngstown Club, Dr. C. L. Cummer, Cleveland, President of the Ohio State Medical Association, and Dr. John H. Stokes, Philadelphia. Dr. Cummer addressed the society on "The Organization Viewpoint". Dr. Stoke's lecture was on "A Panoramic View of Recent Advances in the Treatment of Syphilis".—Bulletin.

Portage County Medical Society held a special meeting May 3 at the Pickwick Arms, Ravenna, with wives and friends of the members as guests. The guest speaker was Dr. Louis J. Karnosh, Cleveland, who spoke on "Insanities of the World's Great Geniuses". About 65 were in attendance and thoroughly enjoyed the splendid address.—E. J. Widdecombe, M.D., Secretary.

Richland County Medical Society in session April 25 was addressed by Dr. George Crile, Cleveland on "The Denervation of the Adrenals". —D. A. Weir, M.D., Secretary.

Stark County Medical Society held its annual May outing on May 16 at the Alliance Country Club. Golf was played during the afternoon. Following a dinner, Dr. J. H. J. Upham, Columbus, dean of the College of Medicine, Ohio State University, addressed the society on "Modern Aspects of Heart Disease After 40 Years of Age". The committee which arranged for the outing consisted of Dr. B. C. Barnard, chairman, Dr. R. L. Rutledge, Dr. M. A. Schlott, Dr. W. G. Siddall and Dr. Floyd R. Stamp.—Bulletin.

The April meeting of the society was held April 12 at the Elks' Club, Canton, with wives of the members as guests. A musical program was presented by the Doctors' Symphony Orchestra, Akron.—Bulletin.

Summit County Medical Society met in regular session May 1 at the Mayflower Hotel, Akron. The program was a Symposium on Pediatrics, with the following speakers: Dr. R. S. Friedley, "Prematures"; Dr. J. G. Kramer, "Infant Feeding"; Dr. J. M. Ulrich, "Colic and Vomiting"; Dr. W. D. Lyon "Common Maternal Errors", and Dr. M. M. Miller, "Anorexia".—Bulletin.

Seventh District

Annual meeting of the Seventh District Medical Society was held May 17 at the Steubenville Country Club. The afternoon was spent at golf followed by a scientific program and dinner. The guest speakers were Dr. J. W. Means, Dr. F. W. Davis and Dr. George Nelson, all of Columbus. Dr. Means spoke on "Surgery of the Breast". A paper on "Eclampsia" was read by Dr. Davis. Dr. Nelson discussed "The Heart".

Belmont County Medical Society met in regular session May 3 at Bellaire. A clinical presentation of some interesting eye conditions was made by Dr. Leo D. Covert.—Bulletin.

Columbiana County Medical Society met on April 10 at Lisbon. The guest speaker was Dr. A. B. Clark, Rochester, Pa., who spoke on "Com-

mon Urological Conditions Encountered by the General Practitioner".—G. E. Byers, M.D., Secretary.

Tuscarawas County Medical Society was entertained May 10 at the home of Dr. W. W. H. Curtis, Dennison. J. A. McGhee, Akron, addressed the society on "Medical Economics".—Bulletin.

Eighth District

Athens County Medical Society met on May 7 at the Bettie Shop, Athens. Thirty-three members were present and listened with marked attention to a paper by Dr. J. J. Coons, Columbus, on "Coronary Thrombosis". It was announced that the June meeting would be held on June 4 at Nelsonville, at which Dr. Paul D. Scofield, Columbus, will speak on "Spinal Anesthesia".—T. A. Copeland, M.D., Secretary.

Fairfield County Medical Society was addressed on May 8 at its meeting at the Mithoff Inn, Rosebank, by Dr. E. E. Campbell, Columbus. Eighteen members were in attendance.—News Clipping.

Guernsey County Medical Society, the Guernsey County Bar Association and the Guernsey County Dental Society held a joint outing May 3 at the Cambridge Country Club with 52 present. The program was as follows: "Medical Jurisprudence", Judge Charles S. Turnbaugh; "Amoebic Dysentery", Dr. Reo Swan and Dr. C. R. Johnson; and brief talks by Dr. Birdie Secrest and Dr. A. W. Boyd, representing the dental profession. Golf and cards followed the luncheon and program.—News Clipping.

Muskingum County—The Academy of Medicine was addressed on May 2 by Dr. I. B. Harris, Columbus. Dr. Harris spoke on "The Acute Abdomen". A supper was served following the program. The members voted to close their offices on Thursday afternoons during the summer months.—Bulletin.

Washington County Medical Socicty met May 9 at the Memorial Hospital, Marietta. Dr. Arthur S. Jones, Huntington, West Virginia, was the guest speaker. He discussed "Peripheral Nerve Injuries".—Bulletin.

Ninth District

Scioto County—A special meeting of the Hempstead Academy of Medicine was held April 23 for the purpose of discussing medical relief to the indigent. Charles W. Gravenkemper, of the county relief administration, was present and discussed the problems of the administration.

At its regular meeting May 14, the academy was addressed by Dr. George M. Curtis, Columbus, on "The Significance of Iodine in the Management of Toxic Goiter".—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)
(Geo. J. Heer, M.D., Secretary Pro Tem.)

May 7—General Session. Program: "Neurological Aspects and Treatment of Disorders Arising from Birth Injuries", Dr. Earl R. Carlson and Dr. Walter O. Klingman, Neurologic Institute, New York City.

May 14—General Session. Program: "Recent Advances in Thoracic Surgery", Dr. John Alexander, Ann Arbor, Michigan.

May 21—General Session. Program: "Diagnosis and Treatment of Some Bone Tumors", Dr. John T. Murphy, Toledo, and Dr. Plinn F. Morse, Detroit.

May 28—General Practitioners' Section. Program: "Medical vs. Surgical Treatment of Chronic Cholecystitis", Dr. C. H. Wells.

Crawford County Medical Society met in regular session May 7 at the Bucyrus City Hospital. Dr. J. A. Riebel, Columbus, addressed the society on "Treatment of Fractures—Anatomical Demonstration".—Bulletin.

Madison County Medical Society was addressed by Dr. George J. Heer, Columbus, at its meeting April 25 at the London Country Club.—News Clipping.

— OSMJ —

Municipally owned and operated hospitals if they are registered with the Bureau of Hospitals, State Department of Health, are entitled to reimbursement under the terms of House Bill No. 80, 115 Ohio Laws, 482, for the care of indigent victims of motor vehicle accidents, according to an opinion rendered by Attorney General John W. Bricker to the Bureau of Inspection and Supervision of Public Offices. The Attorney General held this to be the case even though such indigents had their legal settlement within the confines of the city owning and operating such hospital.

— OSMJ —

By virtue of Section 3143, General Code of Ohio, tubercular persons who cannot afford hospital expenses are entitled to hospital care at the expense of the county at the hospital facilities provided by the county commissioners when such persons are residents of the county even though such residents have a legal settlement within a city in the county, Attorney General John W. Bricker held in a recent opinion to the Bureau of Inspection and Supervision of Public Offices.

— OSMJ —

Coshocton—Members of the Coshocton County Medical Society have voted to close their offices on Thursday afternoons during the summer months.

Deaths in Ohio

Ernest O. Adams, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1893; aged 66; died April 16. Dr. Adams had practiced in Cleveland since graduating from medical school. His widow survives.

Clarence I. Britt, M.D., Columbus; Ohio State University, College of Medicine, 1920; aged 42; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 5 at Saranac Lake, N. Y., following an extended illness. Dr. Britt was a member of the staffs of White Cross, St. Francis and Radium hospitals and a surgeon for the Pennsylvania Railroad. Surviving are his widow, one son, two daughters, his parents, one sister and three brothers.

Giovanni A. Baricelli, M.D., Cleveland; University of Illinois, College of Medicine, Chicago, 1903; aged 61; former member of the Ohio State Medical Association and former Fellow of the American Medical Association, died April 16. His widow survives.

Elijah A. Calloway, M.D., Columbus; Howard University, School of Medicine, Washington, D. C., 1916; aged 45; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died April 23 of appendicitis. Dr. Calloway was active in church, club and social work.

Charles Henri Ferguson, M.D., Toledo; Toledo Medical College, 1896; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died April 25. Dr. Ferguson was born in Canada but had spent the greater part of his life in Toledo. He was a member of the Masonic, Elks, Odd Fellows and Pythian lodges, the Utopian Club and Alpha Phi Lambda fraternity. Surviving are his widow and two sisters.

Jane Nye Gilliford, M.D., Pomeroy; Kansas Medical College, Topeka, Kansas, 1899; aged 67; member of the Ohio State Medical Association and the American Medical Association; died April 23. Dr. Gilliford practiced medicine in Portsmouth and Pittsburgh, Pa., before returning to Pomeroy, her birthplace, following the death of her husband, Dr. Robert Gilliford. She served several years as county health commissioner, resigning in 1931. Dr. Gilliford was a member of the Episcopal Church, the D.A.R. and Order of Eastern Star. One brother survives.

James T. Hanson, M.D., Gallipolis; Medical College of Ohio, Cincinnati, 1874; aged 83; former member of the Ohio State Medical Association and the American Medical Association; died April 20 of a fractured skull received in an automobile accident. Dr. Hanson had been coroner of Gallia County for many years; had served two terms as county auditor, and was a former superintendent of the Athens State Hospital. He belonged to the Masonic and Elk lodges. One son and one daughter survive.

Charles M. Herald, M.D., Elyria; Western Reserve University, School of Medicine, 1916; aged 47; former member of the Ohio State Medical Association and the American Medical Association; died April 19 of heart disease. Dr. Herald has been a resident of Elyria for the past 15 years. He was a member of the staff of the Elyria Memorial Hosiptal. During the World War, he served in the medical corps. His widow and two children survive.

Clarence E. Huston, M.D., Paulding; Medical College of Ohio, Cincinnati, 1893; aged 66; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died April 14 of heart disease. Dr. Huston practiced 15 years at Rushsylvania before moving to Paulding in 1910. He had been health commissioner of Paulding County for a number of years. His widow and two sons, one of whom is Dr. Paul Huston, Cleveland, survive.

Allen J. Ingersoll, M.D., Mentor; Western Reserve University, School of Medicine, 1893; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died April 11 of injuries sustained when struck by an automobile. Dr. Ingersoll was a native of Mentor and had practiced there since graduating from medical school. He had served on the school board for 33 years. His widow, two sisters and one brother survive.

Orlando Fenton Lowry, M.D., Cambridge; Starling Medical College, Columbus, 1889; aged 78; died April 12. Dr. Lowry practiced 10 years at Lore City before locating in Cambridge. He was a former county and city health commissioner, and former member of the board of education. He belonged to the Masonic Lodge. Surviving are two daughters, one son and one sister.

Mary Parlee Manning, M.D., Hamilton; Miami Medical College, Cincinnati, 1904; aged 70; member of the Ohio State Medical Association and

the American Medical Association; died April 11 of pneumonia. Dr. Manning was public school physician, physician at the Children's Home and the juvenile court. She belonged to the Presbyterian Church and Daughters of America. Surviving are two brothers.

Harold Y. Masefield, M.D., Columbus;; Ohio Medical University, 1900; aged 55; former member of the Ohio State Medical Association and of the American Medical Association; died May 3. Dr. Masefield was a member of the Masonic and Moose lodges and was on the staff of White Cross Hospital. His widow and two sisters survive.

Daniel C. Mills, M.D., New Lebanon; Medical College of Ohio, Cincinnati, 1893; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died April 17 of heart disease. Dr. Mills had practiced at New Lebanon for 40 years. He was president of the Farmersville Citizen's Bank and the New Lebanon Telephone Company. Dr. Mills was a member of the Masonic and Odd Fellow lodges. His widow, four sons, one daughter and one sister survive.

Robert B. Newcomb, M.D., Cleveland; Western Reserve University, School of Medicine, 1893; aged 62; former member of the Ohio State Medical Association and the American Medical Association; died March 19. Dr. Newcomb studied medicine for the purpose of preparing himself for a special field in the practice of law. Following his graduation from medical school, Dr. Newcomb studied law, was admitted to the bar and was for many years one of Cleveland's leading attorneys.

James Caldwell Price, M.D., Toledo; Cleveland Pulte Medical College, 1903; aged 65; died April 22 following a stroke of apoplexy. Dr. Price located in Toledo 30 years ago. He was a member of the Toledo charter commission and active in civic affairs. He belonged to the Foresters, Knights of Pythias, and the Masonic Lodge. His widow, three sons, one brother, and one sister survive.

Levi E. Reek, M.D., Piqua; Medical College of Ohio, Cincinnati, 1891; aged 67; died April 15. Dr. Reck had practiced in Piqua since graduating from medical school. He leaves his widow, one son and five brothers.

Arthur E. Snepp, M.D., Dayton; Ohio Medical University, Columbus, 1900; aged 62; died May 5 of heart disease. Dr. Snepp practiced for a short time in Toledo before locating in Dayton. Surviving are his widow and two brothers.

Joseph E. Toot, M.D., East Liverpool; New York University Medical College, 1890; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died April 12. Dr. Toot located in East Liverpool in 1891. His widow and one son, Dr. J. F. Toot, Canton, survive.

Joseph Vadasz, M.D., Cleveland; University of Budapest, School of Medicine, 1909; aged 49; died April 14 of appendicitis. Dr. Vadasz was a junior active member of the Cleveland Academy of Medicine.

William F. Weikal, M.D., Middletown; Eclectic Medical College, Cincinnati, 1903; aged 67; died April 27 following a cerebral hemorrhage. Dr. Weikal located in Middletown in 1903. Some years ago Dr. Weikal established a foundation in memory of a deceased son from which college tuition was paid to a deserving member of the graduating class of the Middletown High School each year. He was a member of the Masonic Lodge. His widow, two sons, two sisters and two brothers survive.

Harry A. Zimmerman, M.D., Youngstown; Miami Medical College, Cincinnati, 1888; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died April 26 of heart disease. Dr. Zimmerman was a 32nd degree Mason. Surviving are his widow, one son and one brother.

KNOWN IN OHIO

Edgar William Guilford, M.D., Newell, West Virginia; University of Pittsburgh, Medical School, 1900; aged 62; died May 2 of paralysis. Dr. Guilford had practiced in Salem for many years before moving to Newell in 1930. He was a Spanish American War veteran and World War veteran. His widow, one son, one daughter and one brother survive.

Arlington C. Holland, M.D., Colorado Springs, Colorado; Starling Medical College, Columbus, 1896; aged 61; Fellow of the American Medical Association; died April 28 of heart disease. Dr. Holland was a former state registrar of vital statistics in Ohio. He was a member of the Masonic Lodge.

— OSMJ —

Eclectic Society In Session

At the closing session of the annual meeting of the Ohio State Eclectic Medical Association, held in Columbus, May 14, 15 and 16, Dr. Jesse K. Bailey, Dayton, was installed as president for the ensuing year and the following additional officers elected: President-elect, Dr. E. M. Wright, Coshocton; vice president, Dr. Fred C. Calloway, Marysville; treasurer, Dr. F. L. Thomas, Marion; recording secretary, Dr. G. E. Jones, Lima; corresponding secretary, Dr. M. R. Bixel, Bluffton. Dr. H. H. Dwire, Bucyrus, was the retiring president. It was voted to hold the 1935 meeting in Cincinnati in the Spring at the time of the meeting of the National Eclectic Medical Association in that city.

NEWS NOTES of OHIO

Toledo—Dr. B. J. Hein addressed the Lucas County Bar Association on "Codes Regulating the Early Practice of Medicine".

Columbus—Students in the College of Medicine, Ohio State University, will be given a chance to criticize the courses taken under a plan whereby at the end of each year a survey will be taken among the students and courses graded on the basis of presentation of subject, content and value.

Troy—What may be done for the crippled child was discussed before the Western Ohio Probation Association in session here by Dr. J. A. Judy, Dayton.

Columbus—Dr. Philip D. Wilson, formerly of Columbus, son of Dr. and Mrs. Edward J. Wilson, this city, has been appointed director of surgery, New York Hospital for the Ruptured and Crippled, New York City.

Dayton—Dr. A. B. Brower was re-elected governor for Ohio, American College of Physicians, at the recent meeting of the college in Chicago.

Xenia—Dr. Ben R. McClellan was re-elected dean of the voluntary medical staff at the Ohio Soldiers' and Sailors' Orphans' Home. Dr. A. C. Messenger, former resident physician at the home, was elected secretary.

Columbus—Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, delivered the commencement address for the College of Medicine, Baylor University, Dallas, Texas, on May 28.

Cincinnati—At a meeting of the Ohio Public Health Association here, Dr. Charles A. Neal, superintendent of the Hamilton County Home, was re-elected president for the ensuing year. Among other officers elected were: Dr. E. B. Pierce, Canton, first vice president; Dr. E. L. Brady, Marion, second vice president, and Dr. Kennon Dunham, a director.

Blanchester—Dr. H. E. Gibson has been elected president of the Blanchester Rotary Club.

New Holland—Dr. John B. May recently celebrated his 92th birthday anniversary.

London—A half holiday on Wednesdays during the summer months will be taken by members of the Madison County Medical Society.

Bellefontaine—Dr. C. K. Startzman addressed the senior class of the Bellefontaine High School on "The Medical Profession".

Marion—Dr. A. Rhu, Marion's oldest practicing physician, recently celebrated his 85th birthday anniversary.

Chillicothe—At a meeting of the Sunset Club, Dr. David A. Perrin read a paper on "Diseases of Middle Life With Special Reference to the Heart". A round-table discussion was engaged in by Drs. H. R. Brown, Charles Miesse, R. E. Bower, M. P. Sproat and J. W. Maxwell.

Youngstown—A Medical-Dental Bureau offering a credit rating service, telephone exchange and collection system has been opened by the Mahoning County Medical Society and the Mahoning County Dental Society.

Circleville—Members of the Pickaway County Medical Society will close their offices on Wednesday afternoons during the summer months.

Zanesville—Dr. C. M. Rambo addressed the local Exchange Club on "Cancer".

Troy—Dr. B. M. Hogle addressed the Troy Rotary Club on "The Making of a Doctor".

East Liverpool—In honor of his 50 years of medical practice, Dr. W. A. Hobbs was given a dinner recently by the physicians of Columbiana County and of Hancock and Beaver counties, Pennsylvania, at Chester, Pa.

Cincinnati—Dr. H. Kennon Dunham, Cincinnati, was elected president of the National Tuberculosis Association for the ensuing year at the final meeting of the board of directors at the 30th annual session of the Association held here.

Sandusky—Dr. H. A. Crossett, formerly of Toledo, has located at Kelley's Island, taking over the practice of the late Dr. John Haas.

Cincinnati—Dr. L. C. Jack has been awarded a three-year Fellowship in surgery at Good Samaritan Hospital where he is completing his internship.

Cincinnati—Dr. J. V. Greenebaum conducted post-graduate lectures in pediatrics at Oklahoma City under the auspices of the Oklahoma State Medical Society and the University of Oklahoma.

Bowerston—Dr. and Mrs. E. L. Miller have announced the birth of a son, Edward Merritt, on April 9. Mrs. Miller was before her marriage Miss Isabel McHarter.

Canton—Dr. E. J. March, president of the staff at Aultman Hospital, was honored with a dinner recently celebrating the completion of 50 years of practice.

HOSPITAL NOTES

—Rev. Carroll H. Lewis has resigned as executive director of Christ Hospital, Cincinnati.

—The club house and grounds of the former Defiance Golf and Country Club has been given by Curtis M. Willock, Pasadena, Calif., to the city of Defiance for conversion into a hospital.

Bethesda Hospital, Zanesville, was left $6,000 by the late Mrs. Mary H. Granger.

—Dr. R. J. Foster has been elected president of the medical staff, Union Hospital, Dover. Dr. M. W. Everhard was elected vice president and Dr. H. E. Reed secretary-treasurer.

—Dr. C. W. Betzner has been appointed director of orthopedics, Deaconess Hospital, Cincinnati.

—Trust funds totaling approximately $3,000,000 were willed to Western Reserve University and Lakeside Hospital, Cleveland, by the late Mrs. Marion C. Tyler.

—Miss Hattie Hyland, formerly of Cleveland, has been appointed superintendent of the Galion Good Samaritan Hosiptal, succeeding Miss Mildred Shumaker, resigned.

—Carl Fridaker, Kenton merchant, had been named manager of the McKitrick Hosiptal, Kenton, succeeding Miss Pearl Minton, resigned.

—The board of trustees of Jewish Hospital, Cincinnati, has confirmed the following officers of the hospital staff: President, Dr. Albert H. Freiberg; vice president, Dr. Moses Salzer; secretary, Dr. Louis G. Heyn; executive board, Dr. E. O. Swartz, Dr. Julien Benjamin and Dr. Samuel Zielonka. The board also confirmed the appointment of Dr. Nathan R. Abrams and Dr. Philmour Bein as residents in medicine and surgery respectively, and the appointment of the following interns for the year beginning July 1, 1934; Alfred Lustberg, Vanderbilt University; Albert P. Harrison, Herbert E. Wyss, David L. Hirst, Lloyd W. Hisrich, Frederick W. Gross, Herbert D. Glick and Walter Felson, University of Cincinnati.

—Dr. C. R. Pontius has been elected president of the staff of the Fremont Memorial Hospital. The following other officers and committeemen were elected: Vice president, Dr. F. L. Moore; secretary, Dr. F. M. Teeple; hospital records, Dr. E. M. Ickes; program, Dr. J. L. Curtin.

—Dr. George E. McCullough has been elected chief of the staff of the Stouder Memorial Hospital, Troy, succeeding Dr. Warren Coleman who resigned after serving in that capacity for the past five years.

—The Ohio Valley Hospital, Steubenville, will share part of the income of the $118,000 estate of the late William R. Davidson under the terms of his will recently probated.

—A committee of five physicians representing the Clark County Medical Society has been named by Dr. E. Paul Greenawalt, president of the society, to confer with the Springfield City Commission relative to a plan of operation for the Springfield City Hospital. The committee, named at the request of the City Commission, is composed of Drs. C. M. Hiestand, N. L. Burrell, C. L. Jones, C. S. Ramsey and Dr. Greenawalt.

—Dr. Frances E. Potter, formerly of Cleveland, has been appointed a member of the staff at the Massillon State Hospital.

— OSMJ —

The Medical Women's National Association will hold its annual meeting in Cleveland, June 10, 11 and 12. The Hotel Cleveland will be the headquarters. Dr. Anna M. Young, Mt. Sinai Hospita, Cleveland, is chairman of the committee on local arrangements.

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PUBLIC HEALTH NOTES

Northwest District, Ohio Federation of Public Health Officials, met on April 18 at Bowling Green. Dr. C. B. Finefrock, health commissioner of Ottawa County, presided. Among those who took part in the program, arranged under the direction of Dr. H. J. Powell, health commissioner of Wood County and secretary of the district, were: Dr. H. G. Southard, state director of health; Dr. Guy T. Wasson, Crawford County health commissioner and president of the Ohio Federation of Public Health Officials; Dr. C. D. Barrett, Michigan State Department of Health, formerly of Lorain County; Dr. Lloyd H. Gaston, chief, Bureau of Child Hygiene, State Department of Health; Leo F. Ey, chief, Division of Laboratories, State Department of Health; I. C. Plummer, chief, Division of Vital Statistics, State Department of Health; Dr. A. B. Lippert, health commissioner of Sidney and Shelby County; Dr. J. J. Sutter, health commissioner of Allen County; Mayor Alva Bachman, Bowling Green, and C. C. Kohl, professor of social science, Bowling Green State College.

—Dr. W. D. Bishop, health commissioner of Darke County, has been elected secretary-treasurer of the Ohio Federation of Public Health Officials, succeeding Dr. E. R. Shaffer, formerly connected with the State Department of Health.

—The State Department of Health has issued a small pamphlet on "Weight and the Diet". It is a slightly revised reprint of an article by Dr. E. R. Hayhurst, published in the January 1 issue of *The Ohio Health News*. Only a small edition has been printed. Copies will be reserved, as far as possible, for physicians whose patients are interested in this subject.

—Tentative agreement for Marion, Crawford, Union, Morrow and Delaware counties to send their indigent tuberculosis patients to a sanitarium to be established in the east wing of the Jane Case Hospital, Delaware, has been reached by the county commissioners of the various counties.

—Dr. Allen W. Freeman, former director of the State Department of Health, has been elected dean of the School of Hygiene and Public Health, Johns Hopkins University, effective July 1, 1934. Dr. Freeman has been professor of public health administration in the school for several years.

——The following list of new health commissioners in Ohio was published in a recent issue of the *Ohio Health News*:

Adams County: Dr. Hazel Sproull, West Union, succeeds Dr. S. J. Ellison, West Union.
Belmont County: Dr. J. B. McMillan (acting), St. Clairsville, succeeds Dr. F. R. Dew, St. Clairsville.
Brown County: Dr. W. L. Faul, Russellville, succeeds Dr. J. G. Anderson, Fayetteville.
Champaign County: Dr. C. E. Thompson, Urbana, succeeds Dr. L. A. Woodburn, Urbana.
Monroe County: Dr. O. C. Jackson, Woodsfield, succeeds Dr. J. W. Weber, Woodsfield.
Morgan County: Dr. A. O. Abraham, McConnelsville, succeeds Dr. James B. Naylor, McConnelsville.
Alliance: Dr. G. O. Rowland succeeds Dr. F. R. Stamp.
Ashland: Dr. G. W. Mehl succeeds Dr. C. B. Meuser.
Cambridge: Mr. Carl M. Oshe succeeds Dr. Clyde L. Vorhies.
Cincinnati: Dr. Owen Fiske (acting), succeeds Dr. W. H. Peters.
Circleville: Mr. Wm. McAbee succeeds Mr. A. J. Lyle.
Conneaut: Dr. Carl W. Dewey succeeds Dr. O. A. Blakeslee, deceased.
East Liverpool: Dr. Roy C. Costello succeeds Dr. Ed. Miskall.
East Palestine: Mr. E. J. Gray succeeds Mr. Arthur S. Johnston.
Gallipolis: Mr. Adolpht Henke, city manager, succeeds Mr. J. R. Quinn.
Girard: Dr. R. V. Clifford succeeds Dr. D. R. Williams.
Kenton: Miss Katherine Fulton, R. N., succeeds Miss Martha Dingess, R. N.
Marietta: Dr. F. S. McGee succeeds Dr. J. B. McClure.
Massillon: Mr. Dwight L. Fisher (acting), succeeds Mr. John H. Williams.
St. Marys: Dr. J. E. Heap succeeds Dr. C. P. McKee.
Toledo: Dr. Basil B. Brim succeeds Dr. W. S. Holley.
Zanesville: Dr. D. G. Caudy succeeds Dr. E. R. Brush.

—Dr. H. G. Southard, State Director of Health; B. O. Skinner, State Director of Education, and John McSweeney, State Director of Public Welfare, have officially approved the Ohio portion of a nation-wide dental health survey that is being conducted by the American Dental Association, in cooperation with the U. S. Public Health Service. Its purposes are threefold, as follows:

(1) To ascertain dental activities in state and local health, education and welfare departments.

(2) To determine dental needs throughout the United States by a cross-section examination of kindergarten and grade-school children, and selected adult groups in institutions, where practicable.

(3) To develop and recommend a constructive dental health program based on the findings.

The survey in Ohio is being conducted by the Dental Health Education Committee of the Ohio State Dental Society.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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Prompt and Full Report

Cincinnati Academy Inaugurates Campaign in Effort to Reduce Appendicitis Death Rate

A campaign of action and education for the purpose of reducing if possible the death rate from appendicitis in Cincinnati has been launched by the Cincinnati Academy of Medicine and the Cincinnati Public Health Federation.

Similar campaigns have been tried in several other cities with considerable success. It is a program which is adaptable to practically every community, large or small, and may be carried on by any county medical society in cooperation with public health officials.

The highpoints of the Cincinnati program are found in the following report submitted by a joint committee on appendicitis and approved by the Council of the Cincinnati Academy of Medicine and the Coordinating Committee of the Cincinnati Public Health Federation:

"Your Joint Committee on Appendicitis respectfully submits the following report:

"1. Studies made by the Public Health Federation indicate for the three-year period 1929-1931, that the death rate from appendicitis in Cincinnati was higher than that of the average of 12 other large American cities.

"2. If Cincinnati had a rate as favorable as that of these 12 cities we should have had 29 fewer deaths a year.

"3. Competent medical opinion seems to be agreed that there are two factors that tend to increase the fatalities from this disease, both of which are in a measure preventable. One is delay between the time of the onset of symptoms and operation. The patient's chance of recovery apparently decreases with each hour of delay. The other is the use of laxatives, since they tend to cause complications particularly peritonitis and to increase the danger of fatality.

"4. A campaign of education carried on by the County Medical Association and the Bureau of Health of Philadelphia in 1930, 1931, 1932, was followed by a reduction in the appendicitis death rate.

"Your Joint Committee is of the opinion that education offers substantial hope of results in saving lives from this disease. We therefore recommend the following educational program:

"Physicians

"I. A symposium at the Academy of Medicine consisting of—

1. A report of the findings of various studies on appendicitis, particularly the Public Health Federation's study showing our comparative mortality rate.
2. The point of view of the internist.
3. The point of view of the surgeon.

"II. The printing of these addresses in the Journal of the Academy.

"III. A short pithy statement for physicians to

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OFFICIAL REGISTRIES FOR NURSES

May we call to the attention of physicians the official registries maintained by Districts of the Ohio State Nurses' Association for the benefit of physicians, hospital, and the public? These registries are operated not for profit and are located in the following cities:

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2157 Euclid Ave., Cleveland	Prospect 1951
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2352 Monroe Street, Toledo	Main 7962
871 W. Riverview Ave., Dayton	Fulton 7211
435 E. Liberty St., Springfield	M. 191
Normandie Hotel, Columbus	ADams 1569
General Hospital, Portsmouth	559

The Ohio State Nurses' Association also operates an employment bureau where nurses may be secured for physicians' and dentists' offices, hospitals, public health nursing organizations, official health organizations, etc.

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be enclosed with the notices of the Academy to its members and to be sent to all Hamilton County physicians not members of the Academy.

"IV. A brief announcement in the Journal about the campaign.

"Pharmacists

"A message to pharmacists urging their cooperation in advising persons complaining of abdominal pain to go to a competent physician and not to take a laxative. Copy of this message to be sent to the Ohio Valley Druggists' Association, with the request that it be printed in their official publication.

"The Public

"1. Newspaper articles for the public on this subject.

"2. A special message to families of the unemployed who can be reached through the Department of Public Welfare and to families reached by public nurses.

"3. Brief radio announcement twice daily for one week.

"4. Short talks to high school children.

"We are requesting the cooperation of the Cincinnati Board of Health, which we consider important to the success of this effort."

The second step in getting the campaign started was in the form of a letter from the Cincinnati Academy of Medicine to every physician in Hamilton County, which said in part:

"We physicians like to think of appendicitis as one disease which we have "whipped." We often wish we were as sure of what to do and when to do it for other diseases as we are for apppendicitis.

"And yet, here are some startling facts which ought to jar us out of our complacency:

"1. One hundred and thirty-five people in Cincinnati die of appendicitis each year. Isn't this number of deaths from a disease which we have "conquered" out of all proportion?

"2. This death rate, 30 out of 100,000, is much higher than that in many other cities. In Philadelphia it is only 14 out of 100,000. In Baltimore only 16. Why should our rate be twice as high?

"3. A 10-year record at the Cincinnati General Hospital shows an operative mortality of about 1.3 per cent in uncomplicated acute appendicitis. After perforation occurs it runs to over 20 per cent. Aren't these figures extremely significant? They are borne out by studies made in Philadelphia and elsewhere.

"We need to preach only two facts. But we need to preach them without ceasing:

"1. The danger of taking cathartics (especially castor oil or magnesium sulphate) under conditions which the patient may consider "Old fashioned belly ache," "a bilious spell" or "an attack of indigestion."

"2. The danger of delaying operation. Efforts to abort an attack of appendicitis by the use of ice bags are far too often weakly substituted for insistence on an immediate operation. Delay can mean only one thing: hourly increased danger of a ruptured appendix.

"You would join in warning people to boil their drinking water if typhoid were rampant in Cincinnati. Is it any less your duty to warn them of the less spectacular but still genuinely threatening dangers of appendicitis in this medically progressive city?"



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ANNUAL MEETING, COLUMBUS, OCTOBER 4, 5, AND 6, 1934

AUG 1 1934
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The OHIO STATE MEDICAL JOURNAL

OWNED AND PUBLISHED MONTHLY BY
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AS A MEDIUM OF SERVICE TO ITS MEMBERS

JULY 1, 1934 VOLUME XXX
Number 7

Economic, Professional and Ethical Principles Upon Which All Medical Service Programs Should Be Based Adopted by A.M.A. House of Delegates at Cleveland Meeting in Which Ohio Physicians Take Prominent Part—Details of Session Will Be Found on Pages 444 to 447 This Issue

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88th Annual Meeting, Ohio State Medical Assn., October 4, 5, 6, 1934, Columbus

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The Ohio State Medical Association

Ohio State Medical Journal

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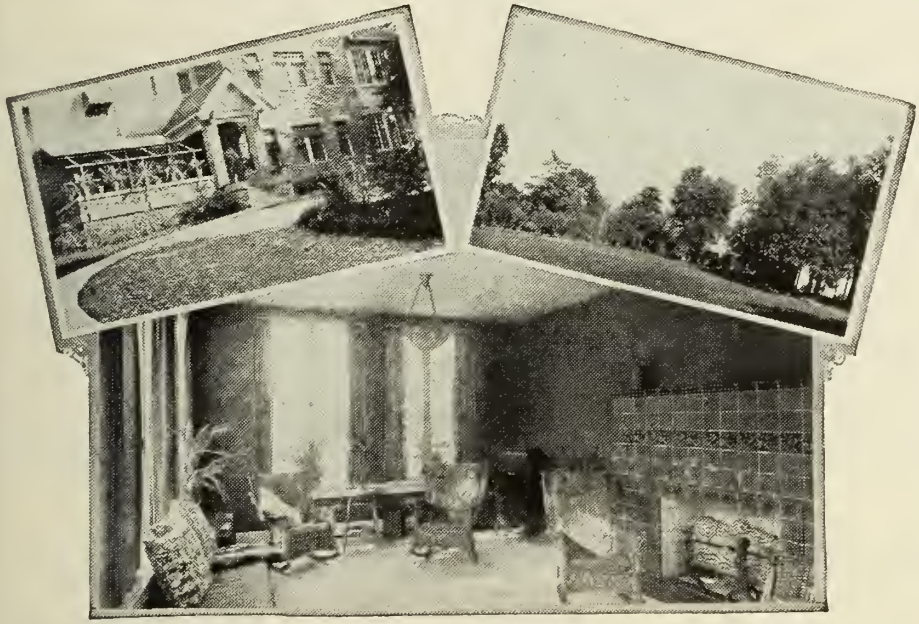
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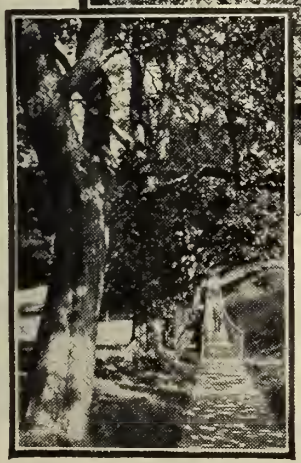
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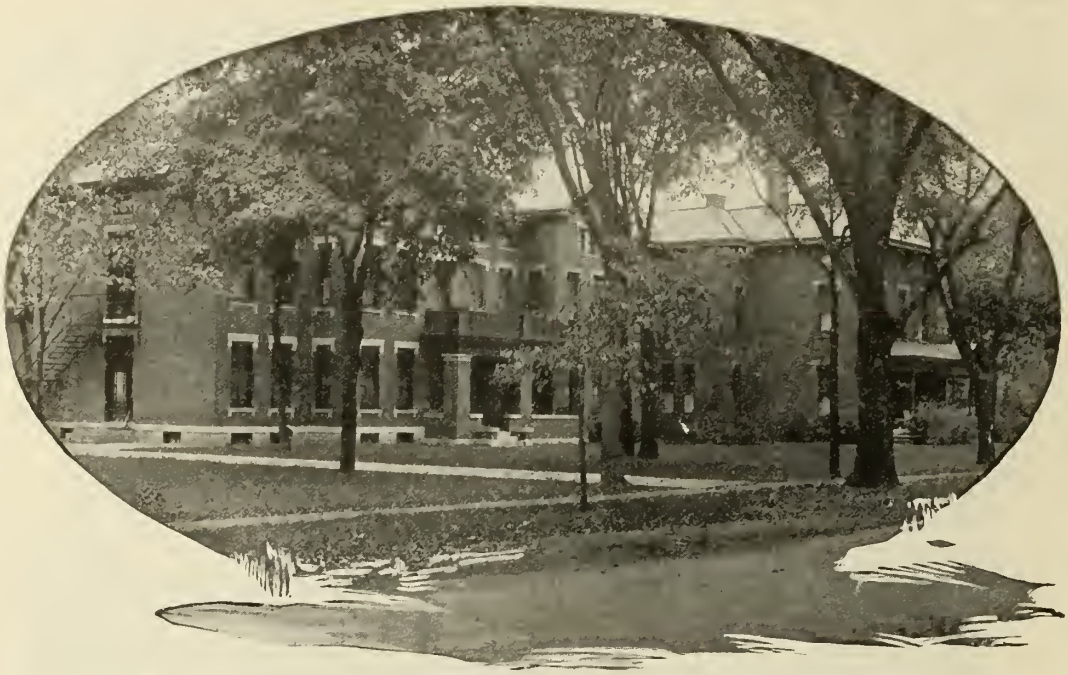


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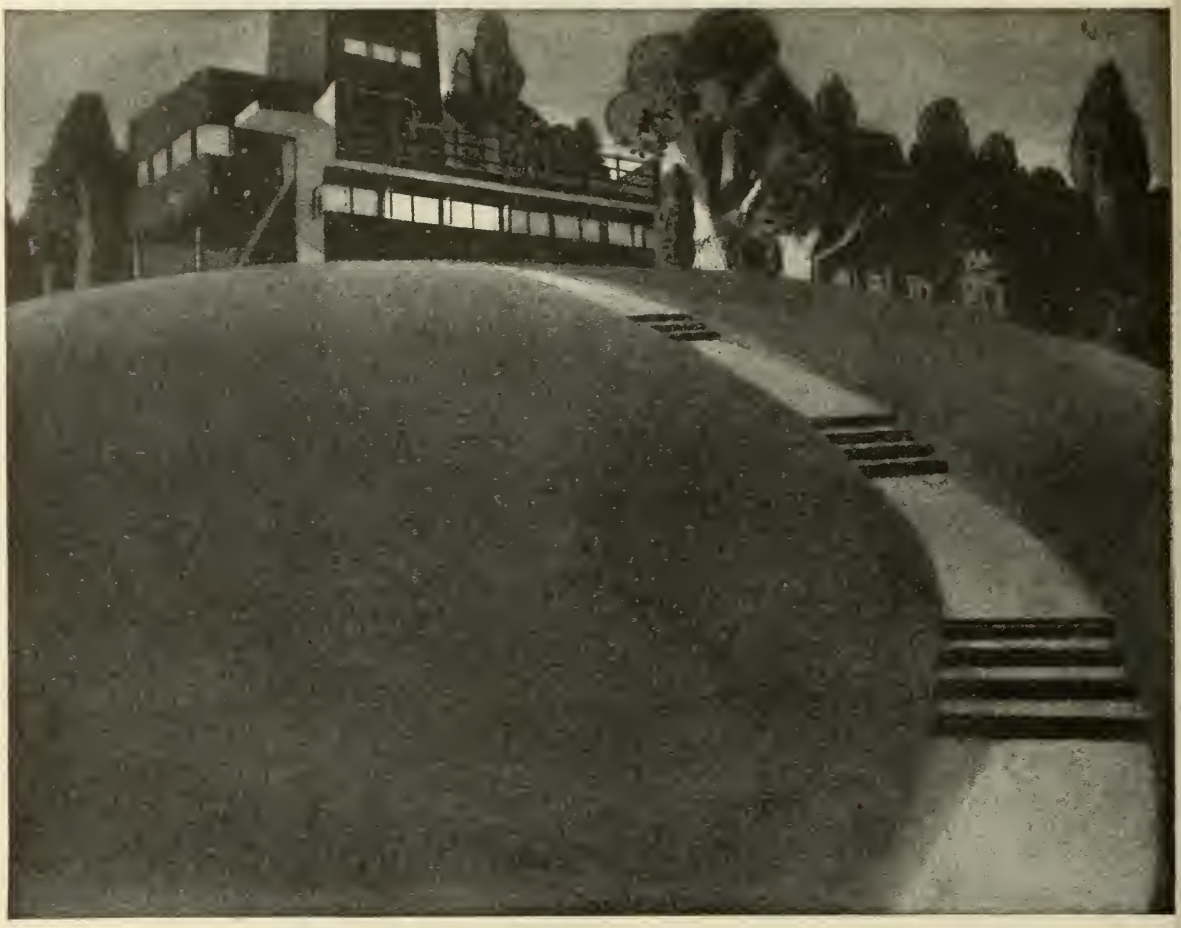
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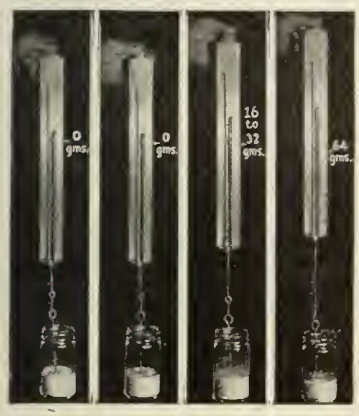
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> The finer the curd the greater the surface area. The greater the surface area the more exposed are the fats, carbohydrates, proteins and salts to the digestive enzymes. Result . . . a more complete utilization of the food elements.

[1] Morse and Talbot: Diseases of Nutrition and Infant Feeding, pg. 59.

[2] Marriott: Infant Nutrition, pg. 43.

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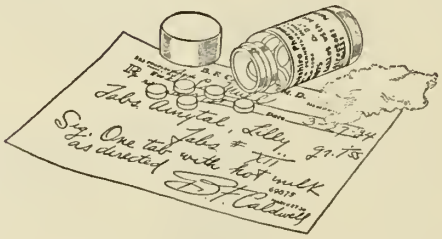
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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Now that the Cleveland session of the American Medical Association has come and gone, Ohio physicians should be looking forward with interest and enthusiasm to attending the 88th Annual Meeting of the Ohio State Medical Association, to be held at the Neil House, Columbus, Thursday, Friday and Saturday, October 4, 5 and 6.

Next Interest Centered on the Annual Meeting

Sessions of the A.M.A. with their splendid scientific programs presented by some of the finest medical talent in the world are unexcelled. However, after all, an A.M.A. meeting does not have quite the appeal to the average physician that a state meeting has, where the opportunity is had for getting together with old friends and acquaintances, obtaining intimate knowledge of the work of Ohio colleagues, and discussing and studying problems that are of peculiar interest to Ohio and the medical profession of this state.

Those who had the privilege of attending the Cleveland A.M.A. session have had their appetite for scientific information stimulated and should be eager to attend the forthcoming meeting of the State Association so that more food for thought can be secured. Those who missed the Cleveland meeting will have an opportunity to forget any disappointment in that respect by spending three days in Columbus next Fall when the Ohio profession puts the finishing touches on the greatest medical spectacle Ohio has witnessed for many years.

Columbus always has proved a fine drawing card for meetings of the State Association. Unless present signs fail, the attendance at the 1934 meeting will equal, if not surpass, that of any previous Annual Meeting.

A program of unusual interest and value is being arranged by the Program Committee of the Council, consisting of Dr. H. V. Paryzek, Cleveland, chairman, Dr. John A. Caldwell, Cincinnati, and Dr. H. M. Platter, Columbus. It will be made to order for both general practitioners and specialists, featuring presentations and discussions on many of the newest medical questions by those who have devoted special study to them. Even the tentative set-up of addresses and lectures, both for the General Sessions and section meetings, indicates that this year's meeting will achieve the Council's goal of making each succeeding annual gathering bigger and better than its predecessors.

Arrangements for the Columbus meeting, exclusive of the scientific program, are rapidly taking shape under the supervision of the Council's Committee on Arrangements, composed of Dr. S. J. Goodman, Columbus, chairman, Dr. E. R. Brush, Zanesville, and Dr. E. M. Huston, Dayton.

The medical profession of Columbus has an enviable record as a host for medical gatherings of all kinds. It has never failed to win loud acclaim for its efficiency and hospitality when called upon to entertain the membership of the State Association. This time promises to be no exception to its unbroken record of batting 100 per cent when it comes to handling annual meeting details and arrangements.

Committees of the Columbus Academy of Medicine, under the general chairmanship of Dr. L. L. Bigelow, a former president of the State Association, are already hard at work on plans and preparations for the October gathering.

Additional details on the Columbus meeting will be published in subsequent issues of *The Journal*, including the official program and information on all the entertainment features.

This brief comment regarding the meeting is an advance notice to the members of the State Association of the fine treat in store for them and the excellent prospects for a record-breaking gathering.

Now is the time for all members to begin making plans to be in Columbus on next October 4, 5 and 6 in order to avoid a conflict with other engagements.

— OSMJ —

When the House of Delegates of the Ohio State Medical Association convenes next October at the time of the 88th Annual Meeting of the State Association in Columbus, those selected by the component county medical societies and academies of medicine to represent them in the business transactions of the State Association will be confronted with an unprecedented number of serious questions relating to the economic

Representation In Organization

and social aspects of medical practice and involving matters of policy and procedure on the part of organized medicine.

Because the medical profession today is in the midst of the most critical and uncertain period in its history, the responsibilities of those who have been delegated to speak and act for the organized medical profession are momentous. The situation is one demanding judicious as well as courageous action on the part of those directing the affairs of medical organization. Hasty and ill-considered action at this time could easily lead to greater complications and an even greater muddle than the one in which the profession finds itself through no fault of its own.

To insure straight-thinking on the numerous complex problems that may come before the House of Delegates and a high degree of unanimity and concerted activity on the part of medical organization, two things are essential:

1. Every member of the House of Delegates should be accurately and as fully informed as possible regarding the vital questions likely to be presented for discussion.

2. Every county society or academy should be represented at every session of the House of Delegates.

Between now and the Annual Meeting every physician who has been elected to sit in the House of Delegates should make a special effort to acquaint himself with the vital factors involved in the serious social and economic questions directly affecting the practice of medicine. Moreover, he should make an effort to analyze these questions dispassionately in the light of the fundamental principles involved and the possible end-results. He should secure and study the sentiment of the majority of the members of his own county society or academy on current questions of local and state-wide importance so that he will be in a position to speak officially for his colleagues.

Every county society or academy should make certain that it will be represented at each session of the House of Delegates. Delegates who have been elected but who are uncertain of attendance should be replaced by those who will be able to do so. Obviously, a delegate unqualified for the job or uninterested in the duties delegated to him will be of little value when it comes to transacting the affairs of the State Association. Some counties have seldom, if ever, been represented at all sessions of the House of Delegates. This situation should not be permitted to happen this year when united and concerted action on the part of the profession is imperative. All the thought the profession is able to muster will be necessary to prepare organized medicine for the strenuous and uncertain times in prospect.

Able and active representation in the House of Delegates of the State Association should be one of the primary objectives of each county medical society or academy. Each is entitled to a part in formulating the policies and activities of the State Association.

— OSMJ —

Legislative Problems Are Approaching

Inasmuch as another regular session of the Ohio General Assembly is in the offing, the following quotation from a legislative resume by Dr. W. C. Woodward, director of the Bureau of Legal Medicine and Legislation, American Medical Association, of medical and public health legislation in the various states during recent months is of unusual significance:

"The cults scored heavily against public health interests in the sessions of 1933-34. . . . Why cult legislation of this character should be so successful is a question calling for searching inquiry by state organizations."

Judging from the unusual activity shown by cultists and foes of scientific medicine and sound public health administration during the last regular session of the State Legislature and present evidences that those groups are preparing for even more vigorous attacks on present medical and health statutes at the forthcoming 91st session of the General Assembly, a great amount of concerted and sustained effort on the part of individuals and groups interested in scientific medicine and public health will be necessary during the coming months to preserve present statutory provisions relating to these two subjects.

Medical organization, being vitally concerned in legislation and regulations dealing with medical and public health questions, has been an effective factor in convincing a majority of the members of past General Assemblies that adequate safeguards should be maintained and destructive legislation on these questions rejected. It must be prepared to again take an active interest in such legislation by acquainting members of the Legislature with the facts on medical and public health matters and stimulating public opinion in support of only constructive legislation of this nature.

Confronted with this sizeable assignment, as well as the problem of meeting numerous issues and legislative proposals bearing on the economic and social aspects of medical practice, organized medicine in Ohio is facing a period that will require unprecedented enterprise and activity on its part if success is to be attained and present safeguards preserved. Naturally, the effectiveness of the part organized medicine will take in the approaching legislative session will be in direct proportion to the active personal interest in important legislative problems of each member of the State Association and on how well the

profession succeeds in sticking together on matters of policy and methods of procedure.

As pointed out in a recent issue of *The Journal*, there is no better time for forming contacts and laying plans for the legislative session than before the primaries and general election. Naturally, follow-up work, and lots of it, must be done after the election and during the legislative session, but now is the opportune time for a frank discussion of medical and health questions with candidates.

— OSMJ —

A Viewpoint of Interest

Present indications are that programs for the complete socialization of medical practice under governmental control and domination and through which medical care would be rendered to all by state-employed physicians will be strongly opposed by others than members of the medical profession.

Of peculiar interest is the following editorial comment, published in *The Christian Science Monitor*, expressing the viewpoint of that faith-healing sect which, although it denies the value of scientific medicine, recognizes the inherent personal right of the individual and senses danger in any program that provides for compulsory participation by the public and mechanized regimentation of practitioners of the healing arts.

Under the heading, "Medical Peonage", *The Monitor* said:

"The family physician who brought kindliness, ready sympathy and unselfish service in large quantities along with his pills and potions has been passing from the American scene; more and more his place has been taken by a complex mechanism, a highly departmentalized professionalism, with impersonal efficiency its dominating sentiment. Now there is a tentative plan for a broad organization of 'state medicine,' as recently outlined by the secretary of the Milbank Memorial Fund of New York. This plan, utterly impersonal, purposes that the entire American population—including that 62 per cent which the fund's spokesman says receive no medical, dental or eye care of any kind—shall be coerced into supporting financially and yielding physically to the domination of a group of state-employed medical men.

"It is difficult to understand why every citizen —including those who by choice would adhere to a rival school, to no school, or who depend upon prayer for healing—should be compelled to comply with such a regulation. Incidentally, it is strangely foreign to the legend of the family doctor, who worked under the motto, 'To each according to his need; from each according to his means.'

"Yet it is just this point which the Milbank fund stresses as its reason for proposing compulsory state medicine. The complexities of modern medical practice, it is claimed, have elevated its cost above the means of many who wish it. Therefore, what could be simpler than for everyone to contribute his proportionate share of the total cost of medical aid, thus minimizing the per capita cost according to the well-known practice of insurance?

"If those who feel they wish material aid in their illnesses were left free to enter or refrain from participation in such a scheme, no criticism could be leveled at it. But, in order to make the plan thoroughly effective, says the fund's secretary, it must be made compulsory upon all. But will that 62 per cent of the people who have not felt the need of medicine sufficiently to seek its aid—although it is offered without cost in countless hospitals and clinics—permit themselves to be saddled with medical peonage?"

— OSMJ —

A Financial Consideration

In a review of Sidney Kingsley's remarkably accurate and inspiring drama, "Men in White", winner of the Pulitzer award, Mary Ross, a staff writer for the *Survey Graphic*, calls particular attention to one statement made by a physician character and interpolates that it "is worth pondering".

Her reference is to the remark of "Dr. Levine", once a promising intern but a failure in the active practice of medicine, that:

"A doctor shouldn't have to worry about money! That's one disease he's not trained to fight. It either corrupts him . . . . or destroys him."

We imagine the implication Miss Ross desires to leave is that the medical profession's sole salvation is some form of state or socialized medicine which will insure to every physician a steady and definite income, regardless of his scientific ability or the quality of his services.

There are "Dr. Levines" in real life. It is easy to imagine how constant worry about money and innumerable reverses and disappointments might win converts to the theory expounded by Kingsley's character.

Yet, it is inconceivable that the great majority of the medical profession are ready to embrace the belief that ability, initiative, resourcefulness, enterprise, ambition, and the rest of the attributes of a successful life should not count for something no matter how hard the struggle.

The idea of putting the practice of medicine on solely a scientific basis and eliminating from it the economic factors that make life itself a battle is a pretty theory. However, when boiled down and analyzed it doesn't make sense. Every physician is entitled to a just return, comparable to his ability and services rendered. Yet, this does

not necessarily imply that all physicians are of equal ability or that all rendered the same degree of public service.

The passion for wealth or perhaps the necessity for funds in order to exist have, undoubtedly, corrupted some physicians and destroyed others. However, these are exceptions. Obviously, the possibilities of corruption are more remote in any system that permits the physician to stand or fall on his merits and when he is judged by those he serves, than in one where services are standardized and merit is displaced by political expediency or influence.

The occasional corruption or destruction of an individual physician, regrettable to be sure, is of less consequence than the corruption or destruction of medicine as a profession and the relegation of physicians as a group to the status of technicians and tradesmen.

— OSMJ —

A Lesson In Socialization

Frequently it takes only an unpretentious lesson in fundamentals to knock the props from under a lot of the high-sounding and sugar-coated theories on economic and social reform.

An illustration is the story going the rounds concerning the experience of a professor of economics in an Iowa university.

It seems in one of the professor's classes was a student who was head of the campus socialist activities and who never overlooked an opportunity to preach equality of income, redistribution of wealth, and similar theories.

One day the professor gave the class a long-promised written examination. One of the questions asked allowed the young disciple of Karl Marx, et al., free play to expound his favorite doctrine.

Later, in announcing the result of the examination to the class, the professor stated that he had decided upon a new system of grading. He had added up all the grades and found the average and was giving each student this average.

The first to protest and expostulate with some heat was the young socialist who explained at length that he had worked hard, denied himself social and recreational pleasures to keep himself informed on the course taught by the professor, "boned" for the examination, and that it wasn't fair to give him the same grade that was given to those in the class who were less prepared and not so well informed on the subject of the examination.

Reaching for the student's examination paper, the professor replied that he had gotten the idea from him and regretted that it didn't meet with his approval.

Then, amid the laughter of the class, the professor calmly announced that perhaps students had better be graded as they had been graded for a great many years, with due recognition for the degrees of individual merit and application.

Obviously, the point made by the professor applies with equal force outside the confines of his particular classroom and indicates that the theorist must eventually give ground to the realist in whatever arena the two may clash, principally because the former fails to take into consideration the frailties of human nature and the difference in individual ability, initiative and productiveness.

No doubt those urging the socialization of medical service and the elimination of competition, individualism and personal initiative from the practice of medicine would be the first to howl bloody murder if academic freedom were abridged and the opportunity to free thinking thwarted in the field of economic and social reform.

— OSMJ —

Qualifications For Health Administration

Not long ago the president (a physician) of the board of health of an Ohio city resigned as a protest against the naming of a layman as health commissioner of the city and asserted in his letter of resignation that "the supervision of health activities, the recognition and control of communicable diseases and the coordination of city, school and county and state health projects demand an individual trained in this work, for which no layman can be expected to qualify".

Ohio statutes provide that the health commissioner of a county or general health district shall be a physician. Nothing in the stautes makes it mandatory that the health commissioner of a city health district be a physician or person trained in sanitation and hygiene. This distinction seems neither reasonable or logical. If it is of benefit to a county to have a physician as head of its health services—and it is——, it is logical to assume that equal benefit would accrue to a city health district by having a physician as director of its public health administration.

Regardless of what the law may or may not say on this question, city administrations certainly should be wise and farsighted enough to realize that their health departments should be headed by the best qualified person obtainable. None other, in our opinions, will fill the bill quite as well as a physician—not any physician, but one with administrative ability, interest in the job, and adequately informed on the scientific requirements and administrative duties of the office.

DEVELOPMENTAL ANOMALIES CAUSING OR PREDISPOSING TO INTESTINAL OBSTRUCTION

By ALAN RICHARDS MORITZ, M.A., M.D.,
CLEVELAND, OHIO

THE most frequently occurring types of intestinal obstruction caused by antenatal maldevelopment are potentially curable lesions. That is to say, the mechanical nature of the obstruction is usually susceptible to surgical correction. It is difficult to classify the types of congenital intestinal obstruction as to "curable" and "incurable" varieties, because it is obvious that curability depends upon much more than the anatomic nature of the obstruction. The various kinds of developmental lesions responsible for obstruction will be described in such a manner that the anatomic types susceptible to correction will be apparent.

The published reports of Pinkerton[16], Dott[6], Ladd[13], Curtis and Kredel[3] and numerous others bear witness to the curability of even the more complicated forms of developmental obstruction. Statistical reviews have indicated that more than 80 per cent of the obstructing lesions are single and not associated with other manifestations of maldevelopment[4, 9, 14].

In the inherently curable forms of embryogenetic obstruction there are two important factors which condition the efficacy of treatment. The first lies in the duration of the obstruction before relief and might be termed the "operative risk". The second is the familiarity of the surgeon with the structure of the more common anomalies responsible for congenital obstruction.

The operability of such a case in terms of "good" and "bad risk" is usually in direct relation to the duration of obstruction and the duration of the obstruction is frequently represented by the pre-operative delay incurred in attempting to determine whether the obstruction is functional or organic. Diagnostic procedures will not be discussed here, but it may be said that the distinction between functional and organic intestinal obstruction in infants is frequently only possible by direct examination of the lesion.

FUNCTIONAL OBSTRUCTION

Functional intestinal obstruction without organic change is frequently encountered so early in life that it must be considered in a discussion of congenital obstruction. Functional obstruction in infants falls into two main groups, dynamic and adynamic.

Dynamic Obstruction—Dynamic obstruction or spasm may manifest itself in the first week, although it is more commonly recognized after the second and third weeks of life. The spasm is usually of a sphincter muscle and of these the cardiac, pyloric and anal sphincters are most commonly affected. Pyloric spasm presents the greatest problem in diagnosis because of its inaccessibility to direct examination and is frequently so severe and so refractory to medical treatment that it cannot be distinguished from organic obstruction. Some investigators believe that if a spasm be continued long enough, organic obstruction will supervene because of hypertrophy of the spastic muscle[9].

Adynamic Obstruction—Congenital adynamic obstruction has been discussed in detail by Bartle[1] in a review of the different varieties of megacolon. It is a condition of chronic progressive distension and hypertrophy of the large intestine with concommitant loss in propulsive action so that the obstruction becomes as real as though caused by stenosis. No anatomic obstruction can be demonstrated and Bartle is of the opinion that the disorder lies in the imbalance of sympathetic nervous action. Ordinarily the obstruction does not appear as early in life as in the dynamic type.

ORGANIC OBSTRUCTION

Organic intestinal obstruction caused or predisposed to by developmental abnormality or fetal disease is of several anatomic types.

Stenosis—Stenosis or narrowing of the lumen in contradistinction to atresia or obliteration of the lumen may be primary or secondary.

The primary type is best exemplified by hypertrophic pyloric stenosis. Here the reduction in the diameter of the lumen is the direct result of hypertrophy of the pyloric muscle. The condition is not uncommon and frequently requires surgical intervention for its relief. It is believed by some investigators that the hypertrophy results from prolonged pyloric spasm, (Finkelstein[9]).

The causes and sites of secondary stenosis are numerous and are to be discussed subsequently according to pathogenetic groups. These include stenoses due to abnormalities in position of the intestine, abnormalities of the mesentery or peritoneum, heterotopia and tumors.

Atresia—The reviews of Davis and Poynter[4], Richter[17], Finkelstein[9] and Koch[12], indicate that the incidence of congenital atresia of some portion of the gastrointestinal tract is about 1 in 4000. The most common form of this anomaly is imperforate anus. The other more common sites are also in situations where there has been unusually complex embryological development as in

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From the Institute of Pathology, Western Reserve University, and the University Hospitals, Cleveland, Ohio.

the duodenum and ileum. The esophagus is less frequently atresic and the stomach is almost never obstructed in this manner.

Obstruction caused by atresia is usually apparent almost immediately after birth and Farber[8] has recently proposed an ingenious method for early diagnosis. Keratinized epithelial cells swallowed by the fetus in utero are a normal constituent of meconium and in cases of intestinal atresia the meconium will fail to contain any of these cells.

The pathogenesis of intestinal atresia is quite obscure and probably because of the paucity of facts relating to its development much has been written in this connection. Richter[17] has reviewed and summarized the more important views.

Foremost of these is that of Sutton[18] who drew attention to the common occurrence of atresia at sites of unusual developmental complexity. He cited as examples; the imperforate pharynx occurring where the fore-gut unites with the oral stoma; the imperforate duodenum where diverticula form from which the liver and pancreas develop and where complicated rotation occurs; the imperforate ileum where the primitive gut communicates with the yolk sac; the imperforate anus where the hind-gut unites with the anal stoma.

This theory is, however, inadequate since in about 15 per cent of all cases the atresic lesions are multiple and not all disposed in sites of unusual developmental intricacy.

A theory advanced by Tandler[19] is based upon his observation that in young embryos the lumen of the gut is normally obliterated by epithelial proliferation with later canalization and establishment of patency It was his belief that atresia is the result of defective or incomplete canalization of this solid epithelial core.

Davis and Poynter[4] have reported a carefully studied case of multiple atresia in which they attribute the atresic lesions to vascular anomaly. Emanual[7] suggested fetal volvulus as a possible cause of segmental atrophy, developmental retardation and atresia.

It is likely that intestinal atresia may result from any one of a number of causes and it is quite unnecessary to attempt to force all of them into one pathogenetic group.

In the case of atresia of the esophagus or anus the atresia is frequently complicated by the presence of fistulas. The most common type of congenital esophageal obstruction is due to atresia of the middle segment. The upper end of the esophagus exists in the form of a muscular pouch communicating with the pharynx and the lower end is represented by a fistulous tube between trachea and esophagus. Correction of such an anomaly is impossible.

The various types of anal and recto-anal atresia deserve more consideration because of their susceptibility to operative relief. It is significant that the anal sphincter is not included in the defect, thus making physiological restitution possible if the gut can be sufficiently mobilized to bring down to the position of the anus. Curtis and Kredel[6] have recently discussed the surgical problem involved in this procedure.

Intestinal Obstruction Predisposed to by Incomplete Secondary Mesenteric Fixation with Normal Fetal Intestinal Rotation.

The development of either volvulus or intussusception is favored by the hypermotility resulting from defective mesenteric attachments. The so-called secondary mesenteric attachments are those occurring to either side of the midline on the posterior abdominal wall after the return of the gut to the body cavity in about the tenth week of fetal life. The development of the mesentery in this period has been described in detail by Frazer and Robbins[10]. The gut returns from the umbilical cord in an elongated form and normally rotates in a counter-clockwise direction, so that the colon comes to lie in a plane ventral to the small intestine, crossing the terminal portion of the duodenum from right to left. Figure 1 illustrates the manner in which secondary mesenteric attachment occur. These secondary attachments are incomplete in almost 25 per cent of all individuals and vary from the simple mobile cecum to complete absence of lateral mesenteric fixation.

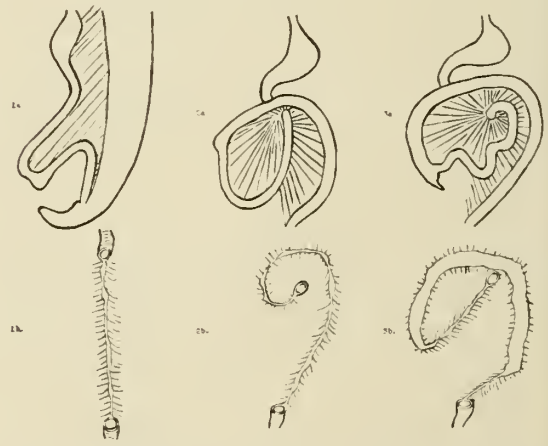


Fig. 1. Diagrams of successive stages of fetal intertinal rotation (1-a, 2-a and 3-a) with corresponding posterior mesenteric attachments (1-b, 2-b and 3-b).

The lesser defects, as represented by varying degrees of mobility of the cecum, occasionally lead either to volvulus of the ileocolic segment or to intussusception of ileum into colon. These accidents may occur either in infancy or later life, and are in most instances immediately completely obstructive. Waugh[20] believes that there is a definite clinical syndrome characterized chiefly by pain and discomfort that is pathognomic of the mobile cecum, independent of volvulus or intussusception.

The most common serious defect in the second-

ary mesenteric attachments has been called "mesenterium commune" and in this condition the entire small and proximal half of the large intestine are suspended from a midline pedicle which is attached to the posterior abdominal wall at the level of the superior mesenteric artery. Although such simplification of the mesentery is not incompatible with health it predisposes to massive volvulus or intussusception[15].

The inception of volvulus in such circumstances may be ante- or post-natal and is occasionally seen in adult life. It may be partially or completely obstructive. The entire jejunum, ileum and proximal portion of the colon usually twist in a clockwise direction so as to reverse the usual relations between small and large intestines and produce obstruction in the terminal portion of the duodenum and in the transverse colon where it crosses behind the duodenum. Figure 2 illustrates the manner in which such a volvulus takes place. The reduction of this type of volvulus is not always possible simply by untwisting the involved loop of gut because of the formation of adhesions at the site of obstruction. This is especially true in cases in which the volvulus has occurred in fetal life with subsequent fixation of the transverse colon behind the duodenum.

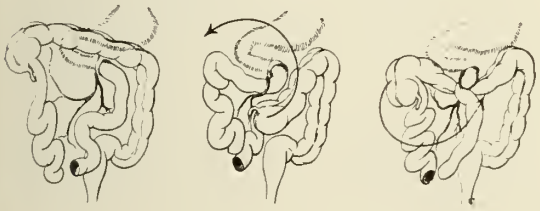


Fig. 2.

Fig. 2. Diagrams illustrating the development of volvulus predisposed to by inadequate mesenteric attachments (mesenterium commune). Arrows indicate direction of rotation required for reduction of volvulus:

(A) Diagram showing the position of the intestine in mesenterium commune before the inception of volvulus.

(B) First stage in the development of volvulus. Intestine has rotated 180° in clock-wise direction. Arrow indicates direction of manipulation required for return to normal position.

(C) Completed volvulus of 360° in clock-wise direction with colon brought behind the twisted third portion of the duodenum. Arrow indicates the direction of rotation required for reduction of volvulus.

A massive volvulus of the intestine in mesenterium commune may simulate conditions more fundamentally abnormal, i.e., reversed intestinal fetal rotation[15]. It must be borne in mind that reversed rotation is an anomaly which has its inception in about the tenth week of fetal life[10] and when reversed rotation occurs, further intestinal and mesenteric development will be conditioned by it. The reversed position would then be normal for that individual, and a surgical manipulation designed to return the gut to the position normal for the average would result in a volvulus in that individual. Ladd[13] has stressed the necessity of adequate exposure and of delivering the entire intestine through the wound in order to distinguish between massive volvulus and malrotation, and to restore normal relations in the case of the former. The amount of twisting of the volvulus varies and in the case reported by Pinkerton[16] the twist was through 450°.

The hypermotility permitted by mesenterium commune also predisposes to intussusception and we have seen intussusception of the ileum into the colon in this condition so extensive that the advancing ileum could be palpated by rectal examination.

Intestinal Obstruction Predisposed to by Defective Mesenteric Attachments with Reversed Fetal Intestinal Rotation.

In the event that the intestine returns to the abdomen from the umbilical cord in early fetal life in such a manner that a reversed or abnormal rotation takes place, adequate secondary fixation usually fails. The elongated gut is suspended by defective or abnormal mesenteric attachments, which predispose it to volvulus or intussusception. Abnormal rotation is relatively uncommon. A detailed description of various types of abnormal rotation which have been complicated by intestinal obstruction has been made by Dott[5] and by Haymond and Dragstedt[11].

Intestinal Obstruction caused by Hernia.

Umbilical hernia, the result of congenital weakness of the abdominal wall at that site, is common but rarely results in obstruction. Occasionally there is a gross defect at the umbilicus with a virtual evisceration into the sac.

Diaphragmatic hernias with high intestinal obstruction result either from muscular defects or from enlargement of the normal openings through the diaphragm. They occur both in infancy and in adult life and may or may not be completely obstructive.

Various other extra-abdominal hernias are complicated by intestinal obstruction. They are, to be sure, predisposed to or caused by imperfect development but their anatomic characteristics are so well understood as to preclude further discussion here.

The several types of intra-abdominal hernia that are made possible by maldevelopment and that cause obstruction deserve mention. The small intestine may become incarcerated within the lesser omental bursa because of an abnormally large foramen, or within an abnormally capacious duodeno-jejunal or ileocolic peritoneal recess. The incarceration or fixation of a large part of the small intestine within the lesser peritoneal sac has been attributed in a few instances to fetal mal-rotation.

Annular defects in the greater omentum or mesentery of the small bowel occasionally permit the passage of the intestine through them with

CHART I

CONGENITAL CAUSES OF INTESTINAL OBSTRUCTION

Type of Obstruction	*Site of Obstruction*	*Age Incidence*	*Degree of Obstruction*
1. No primary anatomic abnormality:			
Dynamic (spasm)	Cardiac, pyloric or anal sphincter	Usually after first few weeks of life	Usually incomplete
Adynamic (dilatation)	Colon	Usually later in infancy or childhood	Incomplete
2. Stenosis	Pylorus	After first few weeks of life	Gradually progressing to completion
3. Atresia	Anus Duodnum Ileum Jejunum Esophagus	Immediately after birth	Complete except in case of external fistulas
4. Defective mesenteric fixation with normal intestinal rotation			
Volvulus	Third portion of duodenum	More common in infancy	Frequently incomplete
Intussusception	Ileum and jejunum	More common in infancy	Complete
5. Defective mesenteric fixation with reversed int. rotation			
Volvulus	Same as 4	Same as 4	Same as 4
Intussusception	Same as 4	Same as 4	Same as 4
6. Hernia:			
Diaphragmatic	High obstruction	Usually in infancy	Variable
Umbilical	Ileum and Jejunum	Usually in infancy	Variable
Inguinal	Ileum and Colon	Usually in adult life	Variable
Duodeno-jejunal recess	Usually jejunum or ileum	Usually in adult life	More frequently complete
Ileocolic recess	" " "	" " "	" "
Lesser omental bursa	" " "	" " "	" "
Annular mesenteric defects	" " "	Variable	" "
7. Annular pancreas	Second portion of duodenum	Usually in adult life	Incomplete
8. Fetal peritonitis	Variable	Variable	Variable
9. Tumors (very rare)	Stomach and Rectum	Early infancy	Variable

obstruction resulting from simple compression or volvulus.

Intestinal Obstruction caused by Annular Pancreas.

Partial obstruction of the second portion of the duodenum by encircling pancreatic tissue is seen both in adult life and in infancy. The subject has been recently reviewed by McNaught[11]. We recently observed a fibrous bar of pancreatic tissue that had encircled and partially obstructed the duodenum of a man 58 years of age.

Intestinal Obstruction caused by Fetal Peritonitis.

Various bands or thickening of the peritoneum have been loosly ascribed to fetal peritonitis, and have been observed to predispose to volvulus or to cause stenosis. Jackson's veil belongs to this ill-defined group. Bands between appendix and gall bladder or between a Meckel's diverticulum and the umbilicus with resulting volvulus have been observed. In the material upon which this study is based there is a case of stenosis of the descending colon apparently caused by a productive inflammation of the peritoneum of the posterior abdominal wall. It was seen in a newly born infant and was complicated by congenital hydronephrosis. The cause of the peritonitis remained undetermined. Cases of intestinal obstruction in this pathogenetic group have no characteristic age incidence and may be partial or complete.

Intestinal Obstruction caused by Congenital Tumors.

Intestinal obstruction caused by congenital tumors is extremely rare. The reviews of Koch[12] and Finkelstein[9] include a few cases of carcinoma of the stomach and rectum in the newly born or in very young infants. Blahd, Maschke & Karsner[2] have reported a case of an obstructive hemangio-endothelioma of the ileum in an infant aged two months.

SUMMARY AND CONCLUSION

Chart I includes the more common developmental anomalies responsible for intestinal ob-

struction. Intestinal obstruction caused or predisposed to by imperfect embryonal or fetal development frequently rests upon a structural defect so simple as to invite surgical rectification. Because of difficulties in exposure and orientation, it is obvious that a thorough understanding must be had as to a possible anatomic nature of the obstructing lesion. This obtains particularly in mesenterium commune where normal relations may be completely distorted.

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INDICATIONS FOR SURGICAL INTERVENTION IN PERIPHERAL VASCULAR DISEASE

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AMPUTATION of an extremity is a confession of therapeutic defeat. Only in the last decade has the surgical approach to the problem of peripheral vascular disease been predicated on other grounds than the removal of a member to relieve intolerable pain or to spare a life from the effects of terminal gangrene.

Arterial spasm as a factor in circulatory impairment, except as the cause of Raynaud's disease, is a comparatively recent concept. We now recognize the importance of vasospasm as a prime factor in many circulatory diseases. Surgery of the sympathetic system, especially sympathetic ganglionectomy in diseases of the peripheral vessels, is relatively a new science. Steadily accumulating data will enable us to crystalize the general indications for its successful clinical application. The determining element in peripheral arterial disease is the volume of blood to the part it supplies. To institute a rational therapy it is therefore necessary to predetermine the presence or absence of vasospasm and organic occlusion, and also to estimate the effects of each on the terminal blood supply. Functional tests in vascular disease will assist in this determination. The ability to produce dilatation of the peripheral vessels is the key to the differentiation of functional from organic disease. Dilatation of the arterioles may be accomplished by the induction of fever, the production of anesthesia (either general, spinal or regional) and by the use of vasodilating drugs.

Brown[1] was the first to point the way to a differentiating test. He used triple typhoid vaccine to induce a rise in body temperature as a means of relieving pain in vascular disease of the extremities. He observed that during the reaction of the fever, the skin temperature of the extremities was decidedly higher than could be explained by the body temperature. He reasoned that this was accounted for by the dilatation of spastically contracted vessels.

Adson & Brown[2] developed and standardized this "fever test" as a means of selection of suitable cases for operation upon the sympathetic ganglia and trunks. They rely upon it not only to determine the presence or absence of vasospasm but also to estimate the probable results of operation. Although the blood volume passing through the peripheral vessels cannot be measured, changes in skin temperature as recorded by the electrothermocouple are a relative index of it. They have found that a patient without vascular disease will, upon receiving an intravenous dose of triple typhoid vaccine, experience a rise in temperature of approximately 3° C. as

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recorded by the mouth thermometer at the height of the fever reaction; whereas the skin temperature of the digits will have increased from 9 to 12 degrees centrigrade. This indicates a relaxation of the vasomotor system, permitting more blood to flood the extremital tissues. In organic disease of the terminal vessels without associated spasm, such as is commonly found in arteriosclerosis, there will be slight if any change in skin temperature in the course of this test.

In purely vasomotor disturbances, such as Raynaud's disease, the differences will be more marked than in the normal—inasmuch as the temperature of the affected digits will be much below the normal before the foreign protein is administered.

In many cases of peripheral vascular disease, particularly in thrombo-angiitis obliterans, organic occlusion and spasmodic constriction are associated. It is in these mixed conditions that such a functional test may be used to indicate the relative importance and responsibility of each mechanism for the syndrome in the individual patient.

Adson[3] considers a given case inoperable unless the rise in digital temperature is two or more times greater than the rise in mouth temperature.

Typhoid vaccine causes chills and other untoward effects in most patients, while in the elderly arteriosclerotic individual, thrombosis of diseased vessels may follow its use. As a therapeutic measure, it also has the disadvantage of producing a relatively short febrile period, and repeated injections may fail in producing any febrile response. These disadvantages have caused other agents to be sought and tried.

A substitute for typhoid vaccine has been studied by Waller[4] who used two cc. of a 2 per cent suspension of sulphur in olive oil deposited intramuscularly. A satisfactory rise in temperature was obtained, accompanied by a maximal vasodilatation. The average duration of fever was 50 hours and no case showed permanent impairment as a result of its use. It was only occasionally followed by a chill. Repeated injections continued to produce fever, indicating that a tolerance is not easily established. The chief objection to sulphur administration is the resulting pain at the site of injection. This begins in about two hours. It is a continuous dull aching pain which lasts for about 24 hours, and is severe enough to require a narcotic for its control.

In theory, the ideal test would be based upon a maximal vasodilatation obtained by the administration of a nontoxic drug which would produce a paralysis of vasoconstrictor fibers. To date no such drug has appeared, although many have been studied. The vasodilating effect of ethyl alcohol was investigated by Miles[5] who recorded the surface temperatures before and after its administration. He was not impressed with the changes in the peripheral circulation.

A similar study of both normal and pathological cases was made by Cook & Brown[6] who observed that the maximum vasodilatation was neither as great nor as constant as that obtained by artificial fever or by anesthesia.

In the past few years, numerous highly favorable reports have been made on the use of acetylcholine as a vasodilating drug. It remained for Kennedy & Barker[7] to investigate this drug in controlled experiments. In a preliminary report covering its use, in both normal control subjects and in those with the more common peripheral vascular diseases, they conclude "that definite measurable reactions occurred in slightly less than 50 per cent of the cases." The drug was fairly rapid in its action but the duration of the effect was comparatively short. The reaction was variable and often incomplete.

Clinical observation alone has taught us that there is marked vasodilatation under general anesthesia, as evidenced by the increased heat, color and sweating of the body surface. These effects show the general response of the superficial vascular bed. This fact was proved by Scott & Morton[8] who have done such valuable research leading toward dependable functional tests. They compared the qualitative and quantitative responses of normal and diseased arteries to inhalation anesthetics, and showed that full surgical anesthesia was accompanied by the abolishment of all vasoconstrictor influence.

White[9], Brill & Lawrence[10] and Morton & Scott[11] all independently demonstrated the paralysis of the vasoconstrictor mechanism of the peripheral vessels under spinal anesthesia. It was the latter investigators who developed the "normal vasodilation level" by their experiments. In a series of patients with normal vascular systems, receiving spinal anesthesia, dermathermic examination of the feet was made. The studies showed a temporary chemical block of sympathetic impulses and a release of peripheral vasoconstrictor activity. The resulting vasodilatation manifested itself by a uniform rise of the surface temperature of the extremities. The degree of this rise was found to have as its lower limit 33°C. over the great toe. This temperature they designated as "the normal vasodilatation level." Thus was furnished an average normal surface temperature top-level, which may be used as a basis for computing the degree of spasm or occlusion in patients with arterial disease when tested under similar conditions.

This method of examination is both practical and safe, as there is but little risk in low spinal

anesthesia. The required hospitalization is the chief objection to the procedure as a routine.

Although the "fever test" and tests under anesthesia (both general and spinal) are dependable, it is desirable that a test be available which is not attended by disagreeable and time consuming conditions; one that may be performed on the ambulatory patient. Seeking such a simplified method, Scott & Morton[12] were prompted to follow the suggestive lead of Lewis, who had used nerve blocking by procaine as a selective quantitative test in Raynaud's disease. They chose the posterior tibial nerve, which supplies the sole of the foot and the plantar surface of the toes.

It can be blocked by procaine below the internal malleolus with ease. In fifteen minutes, anesthesia over the area of distribution is complete. The anesthesia was accompanied by a progressive rise in surface temperature. The maximum temperature averaged less by one degree than the established maximum under spinal anesthesia. By a series of tests it was determined that the lower limit of the normal vasodilatation level by this method is 30.5°C. From this normal, the degree of occlusion in pathological cases can be easily computed. If the temperature of the part fails to advance to the normal vasodilatation level, by just so much is the organic change responsible for the presenting symptoms. If this degree of occlusion is not more than 2°C. then treatment directed toward the elimination of spasm may be instituted.

By careful history and physical examination, the presence of peripheral vascular disease can be ascertained quite readily. The age and sex of the patient, with history of onset and progression of symptoms together with the character and extent of pain, and sensory changes will, in the great majority of cases, properly classify the disease. The relative amount of circulatory impairment may be estimated through an examination involving an observation of trophic changes, the pulsation of arteries, the presence of pallor, rubor or cyanosis, and the study of these color changes through change of posture, exposure to cold and heat, and after compression.

Age has a helpful bearing on the diagnosis, as arterio-sclerosis occurs usually after fifty-five while thrombo-angiitis is most frequently found between the ages of twenty-five and forty-five. Raynaud's and allied vasomotor diseases more commonly occur from sixteen to thirty-five years.

Sex is an important diagnostic aid as 95 per cent of the pure vasospastic conditions occur in females; whereas in 99 per cent of the cases, thrombo-angiitis is found in men. Arteriosclerosis is also preponderantly a male disease—90 per cent occurring in this sex.

Progression of the Symptom Complex is important in separating the type of disease, as the vasospastic type exhibit paroxysmal seizures particularly when exposed to the influence of cold. Between attacks there is complete freedom from symptoms, while in the occlusive conditions the tendency is toward persistent and progressive increase in all symptoms.

Impeded peripheral circulation from whatever cause produces a group of symptoms and signs that are, except in the very incipient stages, easily recognized. The symptoms and signs consist of changes in pulsation, color, and in temperature—associated with sensory changes and frequently pain, followed by molecular or massive necrosis of tissues.

Pulsation of supplying arteries is checked routinely by palpation of femoral, popliteal, posterior tibial and dorsalis pedis. In all except 5 per cent of the cases of occlusive disease, the peripheral arteries will be found with diminished or absent pulsation. In vasospastic conditions as typified by Raynaud's disease, pulsation is normal.

Color Changes vary with the type of disease and with the degree of vascular involvement. It may be observed in but one toe or finger, or the whole foot or hand, and may vary from cadaveric pallor through pink and red to deep purple. Its changes are marked by postural alterations.

Pallor which is due to absence of blood is apparent in any position of limb in the vasospastic state, and in Raynaud's is followed by cyanosis which remains until the attack is over. It is characteristically produced by elevation of the extremity in occlusive disease. Rubor, or cyanosis, is the result of blood stasis. It is demonstrable by dependent position of the extremity even early in occlusive disease. It is most marked in thromboangiitis, and may point to the diagnosis long before other signs appear. Buerger explains the phenomenon as a reflex dilatation of the skin capillaries after they have been emptied by elevation; the collateral circulation being insufficient to force the blood upward against gravity. In the later stages of vascular disease, cyanosis becomes chronic and always precedes gangrene.

Sensation is commonly affected, and a feeling of numbness with coldness, associated with tingling and other forms of paraesthesias and hyperaesthesia is not uncommonly experienced.

Pain may appear early in the course of vascular disease. It may vary from a numbness and aching to the most excruciating pain of lancinating or burning character. The gradual development of dull aching or cramping pain in the calf of the leg or in the foot arches after walking moderate distances, and in cold weather, is a common complaint and is usually ascribed to either rheumatism or weak arches. Intermittent claudication may be found in all types of oc-

clusive disease, but does not occur in Raynaud's syndrome.

"Rest Pain" occurs in a later stage of occlusive disease and appears after prolonged recumbency. It is usually severe and lancinating.

Trophic disturbances of varying severity occur. Thickening and distortion of nails, callosities and decalcification of bones are among the minor changes—while ulceration and gangrene frequently appear in the later stages. The ulceration and gangrene of Raynaud's disease differ from that occurring in occlusive disease. Mass gangrene of a digit does not occur, but dry punched out ulcers appear at the tips of fingers or toes, while the gangrene is usually superficial, involving skin only, and this in small patches.

The application of rational treatment must be based on a more accurate knowledge of the physiological response that it is possible to obtain by this routine study. It is necessary to determine the presence or absence of organic occlusion and of vasospasm and the relative activity of each in the production of the impediment to the circulation.

Our present knowledge of the causes of disease of the peripheral vessels is most meager. Our treatment is therefor aimed at the relief of pain, the encouragement of an increased blood supply to the extremity, and the prevention of molecular or massive necrosis of tissue. These objects are sometimes attained by so-called conservative treatment, and sometimes by surgical procedures. The latter are aimed at the interruption of vasoconstrictor impulses through chemical destruction or surgical division of their pathways. The procedures consist of alcohol injection of nerves or ganglia, perivascular sympathectomy, ramisectomy and ganglionectomy.

In the University Clinic, the attempt is made to evaluate the degree of vasospasm present in all cases of vascular disease as the index to therapeutic procedure. The basis of the functional tests used is the study of the surface temperatures before and after interrupting the vasoconstrictor impulses to the affected part. In the upper extremity, a general anesthetic is administered—or the cervical and thoracic ganglia are injected with novocaine. If the lower extremity is to be studied, a spinal anesthetic is administered or the posterior tibial nerve is blocked. We have had no experience with the temporary blocking by procaine injection of the lumbar sympathetic ganglia.

The technique of the tests closely follows that of Morton & Scott. The patient to be tested is recumbent in a room with nearly constant temperature between 66° and 70°F. The extremities are exposed below the elbows or knees for thirty minutes before the temperatures are recorded. The thermocouple used is that developed by the Taylor Instrument Company, in co-operation with Scott[13] and sold under the trade name of "Dermatherm." Readings are made from palmar or plantar surfaces of the terminal phalanges, from the midpalm and midsole, and from the dorsum of hand or foot. After this record is made, the anesthetic (local, general or spinal) is administered. When full anesthesia is obtained, the temperatures of the same areas are again recorded. The difference in degrees of temperature of the same area reflects the changes in vessel function. By subtracting the highest digital temperature recorded during anesthesia from the known normal vasodilatation level, the degree of organic obstruction is determined. For example —if the temperature of the toe increases under block anesthesia but fails to equal the normal level of 30.5°C by 1°C, there is vessel spasm present but the occlusion index is 1°C.

If the temperature shows no increase during anesthesia, the circulatory inhibition is solely the result of organic changes and therapeutic efforts such as the administration of vasodilating drugs, alcohol injections of nerves or ganglia and the operative procedures on the rami and ganglia will be of no avail.

In many cases of peripheral vascular disease, amputation ultimately becomes necessary. Terminal gangrene will be its chief indication. Intractable pain is now responsible for the loss of many limbs, particularly in thrombo-angiitis obliterans. A growing clinical experience seems to indicate that this will eventually be controlled through an attack on the nervous system.

The location and extent of mechanical occlusion of the terminal circulation of an extremity can be estimated by the absence of pulsation of the vessels at certain levels; by the changes in color associated with change in posture and following constriction; and by variations in surface temperatures. These criteria are relative and inexact. A more precise method will doubtless be perfected through arteriography. Furthermore, the radiographic exposition of the circulatory apparatus will demonstrate congenital or acquired anomalies in the course of the arteries and show the extent of collateral circulation.

Arteriography should then be helpful in choosing the level at which amputation must be made. Most amputations for vascular disease of the lower extremity are made through the thigh to insure adequate blood supply to the remaining stump. By arteriography, the location of the occlusion and the adequacy of the collateral circulation can be visualized and thus indicate whether greater length of limb may safely be conserved.

The introduction of radiopaque substances into the blood vessels is not particularly recent in con-

cept or practice. Iodized oil was the preparation first used—then followed bromic and iodic compounds. Experimental and clinical results showed frequent severe local irritation of the vessels and in some cases, dangerous general reactions.

Radt[14] in 1930 first published his results on the use of thorium in a colloid solution for the demonstration of the liver and spleen by radiological method. Since this time, a great amount of research has been accomplished in Europe using this medium, now procurable under the trade name of thorotrast. Thorotrast contains 20 per cent thorium dioxide in the colloidal state. Upon entering the blood channels, the thorium content is deposited throughout the cells of the reticuloendothelial system. Such investigation as has been directed toward its fate in the body seems to indicate an extremely slow elimination through the urine, bile and lungs.

Many observers believe this substance solves the problem of a radiopaque medium for intravascular use. Only occasionally has its use been followed by such reactions as chilliness, mild fever and vomiting; and thorotrast yields good radiograms and is easy and painless to inject. The evidence to date is somewhat conflicting as to the potential dangers involved in its use. This was recently reflected in the unfavorable report of the Council on Pharmacy and Chemistry of the A.M.A[15] The possibility of its conversion into mesothorium and radiothorium, and thus developing a radio-sensitivity of the tissues to *X*-rays, has been emphasized.

Because of these doubts regarding the possibility of very late untoward results, we have not adopted thorotrast in our work but are now using skiodan. Skiodan is mono-iodo-methane sulphonate of sodium, which is an organic compound containing 52 per cent of iodine in fixed combination. It has been used in intravenous urography and instrumental pyelography for the past several years in this country and is considered safe for intravenous use by the urologist. Its one contra-indication is serious bilateral impairment of renal function. Skiodan is marketed in Europe under the trade name of abrodil. Dos Santos [16] first made use of abrodil (skiodan) in a mixture with sodium iodide as a contrast medium for arteriography in 1931. He soon replaced sodium iodid by abrodil[17] because it was well tolerated, less toxic, and the roentgenograms were of much better quality. We have found no other reference to the use of skiodan for arteriography. In clinical use, it seems to meet all requirements, permitting a satisfactory visualization of the peripheral arteries, and causing no immediate or late untoward effects. It has the one disadvantage of producing sufficient pain during injection to require the use of nitrous oxide or low spinal anesthesia.

The following technique has been found to be satisfactory:—The *X*-ray plate is placed beneath the extremity and the tube adjusted above it. The brachial or femoral artery is exposed through a short incision over its course just below the axilla or groin. The artery is compressed by the finger tip just above the point of injection. A No. 19 needle attached to a syringe containing 20 cc. of skiodan warmed to body temperature is inserted into the lumen of the artery. The content of the syringe is discharged into the vessel at the rate of 2 cc. per second. When 10 cc. have entered, the compressing finger is momentarily removed to permit a little blood to flow through the vessel thus driving the contrast medium to the periphery. Just before the last of the solution enters the vessel, the signal for the *X*-ray exposure is given. The compression of the vessel may be continued, the *X*-ray plates changed and a second exposure made in a different plane. Pressure for about five minutes over the point of arterial puncture, controls the hemorrhage. If a technical error has resulted in failure to obtain a satisfactory roentgenogram, the injection may be repeated at the same sitting without fear of overdosage, as 50 cc. is the standard intravenous dose for adults when used for urography.

Surgery of the peripheral vascular system has received a decided impetus from workers in this field during the past five years. Our horizon has been greatly widened by their efforts. A wider clinical experience is necessary for the development of unfailing criteria measuring the indications for and the nature of the surgical approach to this great problem.

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ANGIOMATA OF THE FACE AND MOUTH

By CHARLES M. CLARK, M.D.,
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ANGIOMATA about the face and head are very common but little is found in the literature except reports of unusual cases. They are considered as congenital, vascular neoplasms occurring before birth or soon after, although some do not appear until later in life. A few are present at birth in the form of small vascular lesions and rapidly develop into very extensive conditions. Some are single while in other cases they occur multiple and in many different locations, often found on the face, mouth and upper respiratory tracts of the same patient.

Histologically they are divided into two chief types (1) Hemangiomas, (2) Lymphangiomas. Pseudoangiomas may be included as a third type but these consist of dilated capillaries including the varices, lymphectasia and are not true neoplasms.

Angiomata vary in appearance from smooth, bluish red discolorations of the skin and mucosa to extensive, deep, cavernous masses composed of blood or lymph, often causing hideous deformities and interfering with the normal development of what would otherwise be a normal child.

The histological structure of angiomata is varied, being derived from either blood or lymph tissues, as in the case reported by Myron A. Zacks, "Lymph Hemangiomas of the Nose, Palate and Tongue", *Laryngoscope*, 1931.

Simple or superficial hemangiomas consist of newly formed capillary blood vessels with either thin or thickened walls and surrounded by a stroma of connective tissue.

Cavernous angiomas are composed almost entirely of new blood vessels and blood spaces lined with endothelial cells communicating with one another, and filled with blood that retains its normal qualities. These blood spaces vary greatly in shape and size and are surrounded by large quantities of fibrillar connective tissue with some smooth muscle tissue.

Lymphangiomas involve the lymph system but in some cases you may find both the blood and lymph system involved in the same tumor, as the case reported by Zacks and mentioned above. A true lymphangioma consists of new growths filled with dilated lymph spaces; these spaces are lined with endothelium and supposed to originate in newly formed lymph channels. A substance resembling lymph is usually found in these spaces.

Pseudoangiomas consist of dilations or enlarged spaces in pre-existing vessels of normal tissues or may sometimes be found as part of the vascular structure of a benign tumor formation.

The symptoms of these neoplasms, like any other type, depend a great deal on the location, and unless connected with some special nerve or organ, symptoms are absent. Many cases are seen in the orbit where pressure may affect the optic nerve and because of connection with the deep vessels, visible pulsation is present, which makes it difficult to differentiate from an aneurism or exophthalmus. The ones located in the mouth, throat and nose are easily injured, often resulting in severe hemorrhages, also when the tongue is involved the growth may become so large it is impossible to take solid foods. The hemangiomas that occur about the face are often small at first but if untreated sometimes grow very rapidly making it impossible to get a good cosmetic result.

Pharyngeal vascular tumors will give the usual symptoms of obstruction, such as choking sensations, difficult breathing or swallowing, varying in degree as the spaces become filled or emptied of blood or lymph.

Hemangiomas may be associated with other congenital abnormalities, such as deformities of the eyelids, with an absence of some parts of the lid structure, congenital bone defects, especially of the frontal, nasal and malar bones, where the soft mass will protrude through the openings in the bone and recede under pressure or change of posture. Bone absorption from the constant pressure of a large, pulsating hemangioma may occur, as in the case reported by Geronimi in 1931.

In his case report the condition occurred in a

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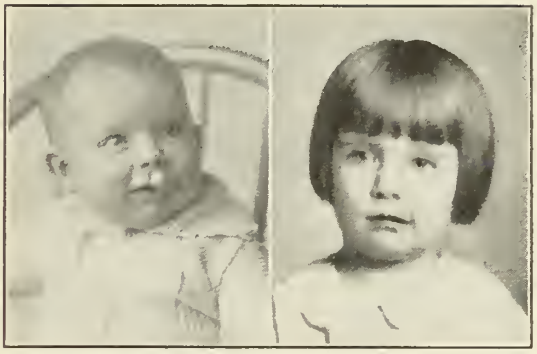
FIGURE I



No. 1. Cavernous Hemangioma before treatment with radium.

No. 2. Same case after treatment with radium.

FIGURE II



No. 3. Small cavernous Hemangioma before treatment with radium.

No. 4. Same case after treatment.

child one year old and began following an injury to the jaw, rapidly spreading until it involved many different parts of the face and mouth, resulting in loss of bone by pressure absorption. Such cases as this undoubtedly are not congenital and must be attributed to trauma.

TREATMENT

The treatment of these conditions is by no means uniform and all methods combined will not produce perfect results in all cases. Many factors have to be considered in determining the best form of treatment for a given case, such as the location of the growth, the age of the patient, the proximity to vital organs, whether the growth is covered with normal skin or mucosa and whether it can be completely removed, etc.

In reviewing the literature I find different authors are using different methods of treatment, offering convincing arguments in favor of his own technique, and all reporting good results.

The different kinds of treatments that have been used in the past and are now being used are (1) Chemical cauterants, such as arsenic, nitric acid, carbonic acid snow; (2) *X*-ray; (3) Surgical diathermy or electrical coagulation; (4) Radium; (5) Surgery. About the face and head the treatment that gives the best cosmetic result should be selected. My experience has convinced me there are two methods that are superior to all others, surgical diathermy and radium.

Surgery can be used to remove these tumor formations if they are not large and in locations where the resulting scars are not visible, although recurrence and post-operative hemorrhages are quite common. Friedheim reported a case of hemato-lymphangioma of the tongue in 1931 where extensive recurrences occurred after surgery, stating it usually required repeated operations, and was impossible to remove the entire growth. Dabney in *Annals of Otology, Rhinology and Laryngology*, 1931, reported a case "Angioma of the Nasal Septum", removed by surgery with no recurrence after two years, stating his case was very unusual as they often recurred after operation.

Cauterants as mentioned above are not easily controlled and always result in excessive scar formation, no matter how small the growth is.

In 1930 Arturo Crocco reported a case of angioma of the orbit treated by electric coagulation and radium combined, stating that surgery in such cases was too uncertain and often resulted in severe hemorrhages.

Surgical diathermy is a very efficient method of treating many of these vascular neoplasms but it is no respector of tissues, as it affects normal and abnormal cells alike. There are limitations to its use and should be used carefully and only in selected cases.

Electro-chemical cauterization can be used where the growth is small as the cells will only be affected 1 mm. from the point of the electrode, it can be used without an anesthetic but requires repeated treatments even for a small area of involvement.

Diathermic coagulation can be used for more extensive growths that are located deeply, especially where the overlying membrane is normal, as the coagulating points can be passed into the growth through a small opening without leaving external scars. Its action is much more rapid and destructive than other methods and unless care is used, sloughing and hemorrhage may result.

For many years radium has been recognized as a specific for vascular neoplasms. Abbe in the *Medical Record*, 1915, reported three cases of lymphangioma of the tongue successfully treated by radium. In the *Journal-Lancet*, Dec., 1916, New reported two cases of lymphangioma of the tongue treated successfully by radium at the Mayo Clinic. A. Baccaredda in 1931 reported a case of hemo-lymphangioma of the mouth which was congenital and stated that he preferred radium to either surgery or electric coagulation. E. Geronimi in 1931 published an article on the use of radium and electro-therapy in tuberose

FIGURE III



Microscopical Section, Hemangioma.

FIGURE IV



Lymph Angioma, microscopical section.

angioma of the face. He thinks radium is indicated in small and superficial angiomas, but its rays are not very effective in the cavernous types, although he does not state what technique he used in this class of case. He concludes that electric coagulation is the really sovereign treatment for vascular tumors and results in radical cures.

Over a period of years I have been much gratified with the results obtained with radium in the treatment of angiomas. In only a few cases have I had to resort to other methods. Many times poor results have been reported with radium but my observation has been that the cases where good results are not obtained, the fault is with the method used and not with the radium.

Radium rays have both a destructive and alterative action on cells, also cells of different individuals react differently to a given dosage of radium, so it is important in starting treatment to go carefully at first to prevent extensive reactions or burns. The greatest care should be exercised in treating the superficial types, or "Port Wine" stains about the face.

The technique I use is to mark off the skin with a pencil in areas two inches square and keep a radium plaque containing 25 mgs. radium with the alpha ray eliminated by screening, moving over this area for 15 minutes repeat this in seven to ten days unless there is too much reaction. If so, wait until the reaction has cleared up, then gradually increase the dosage each time sufficient to cause a reaction resembling a mild sunburn. Unless the radium is kept moving the redness does not clear up uniformly and becomes somewhat mottled.

I prefer to use radium in treating practically all cases of cavernous angiomas. In the small type where there is only a slight elevation, 25 mgs. of radium is screened with 2 mm. of rubber and 2 mm. of lead, then placed over an area about 1" square and allowed to remain two hours. This is repeated every two to three weeks unless reaction is present.

In the extensive cavernous types, I use 5 mg. needles of radium element, make a small nick through the normal skin and place the needles about ½" apart into the cavity. This prevents puncturing the vascular tissue and is a protection against hemorrhage. Dosage in such cases in children should be kept down to 250-300 mg. hours and even this dosage will sometimes result in toxemia, characterized by high temperature, vomiting and loss in weight. This type of treatment should not be repeated until all symptoms have subsided. The dosage may be increased gradually depending on reactions, until the growth has cleared up. In adults the dosage is usually somewhat larger than in children.

It is impossible to form an accurate opinion beforehand as to the cosmetic result in all cases but in many of the smaller ones a perfect result is obtained, while the larger types naturally are left with considerable scar tissue.

In conclusion I wish to state emphatically that in my opinion there is no form of treatment that will produce such pleasing results in angiomas, as radium, when it is used properly and in sufficient dosage.

OHIO BUILDING.

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COMPLMENTAL FEEDING OF THE NEWBORN

A Comparison of Plain Cow's Milk with Cow's Milk Modified by the Base Exchange Method

By ANDREWS ROGERS, M.D., CHARLES W. PAVEY, M. D., and ANITA WILLIAMS, R. N.,

COLUMBUS, OHIO

IN the past few years we have noticed a decided decrease in the number of mothers who were capable of producing sufficient breast milk to feed their babies satisfactorily without resorting to more or less complemental feeding.

Whether this is due to a generic tendency or to the current economic duress among clinical patients or to other causes we are unable to say but regardless of the cause, the situation has focused our attention upon the desirability of finding a formula that will provide the optimum complement for breast feeding.

We felt that the type of feeding that minimized the initial loss of weight, regurgitation, vomiting and diarrhea and that would produce a satisfactory gain over birth-weight by the time of discharge could be taken as representing this optimum. In addition to the foregoing, due consideration was given to the necessity of finding the formula that would be suitable for the greatest percentage of babies without the necessity of special modification so that it could generally be used as a routine in the obstetrical nursery. Inasmuch as we are obliged to deal with many babies of indigent parents at The University Hospital it was essential that the complemental feeding, particularly if it was to be continued after leaving the hospital, be practical from the standpoint of low cost and easy availability.

For several years we have used milk from the University herd in the preparation of our basic formula and from time to time have tried variations of the proportions of milk and water and the amount and type of carbohydrate. For some time now, after trying numerous other combinations, we have contented ourselves with a mixture of twelve ounces of water, twelve ounces of milk, two tablespoons of ordinary cane sugar and half a dram of table salt. Instead of plain water for a diluent we use a thin barley gruel.

For straight formula feeding we found that acidulated milk was superior to the above formula unacidulated, presumably due to the finer, softer curd resulting from acidulation. We soon found, however, that the acidulated milk was entirely unsuited for use as a complement to breast milk because the baby simply refused to take the sour formula after being accustomed to the sweet breast milk. For this reason we were forced to abandon the use of acidulated milk. Recently, however, a new process for treating milk was made available commercially and by this process, known as the base exchange treatment, it is possible to produce a milk not differing in taste from ordinary milk and having a curd as fine and flocculent as could be produced by any method of acidulation. Furthermore, this milk is available at only two cents a quart more than ordinary milk.

The process of treating such milk consists in brief of raising the acid content of the milk, by the addition of citric acid, from about 0.13 per cent to 0.3 per cent calculated as lactic acid. The milk is then passed over a bed of sodium aluminum silicate in the form of zeolite sand. During this contact a base exchange takes place and some of the calcium ions are replaced by sodium ions and the acidity is reduced to that of normal cow's milk (PH 6.8). In this process approximately 20 per cent of the calcium is removed and when rennin is added to such milk no curd is formed. The reduction in the amount of calcium is not objectionable inasmuch as the available calcium and calcium retention are actually increased although the total calcium content of the milk is reduced about one-fifth. The zeolite process reduces the phosphorus content

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also so that the calcium-phosphorus ratio of the milk is unaltered.

For the purpose of a preliminary comparison of regular milk and milk of the same quality treated by the base exchange process we ran series using alternate babies just as admitted to the nursery, on the treated milk and on regular milk using the same proportions for both formulae. The weights were compared for the two series using the weight at birth, and on the fourth, seventh, and tenth day.

The babies on regular milk had an average birth weight of seven pounds and three ounces and those on the base exchange milk averaged seven pounds and three fourths of an ounce.

The following table shows the comparative results of feeding fifty babies on a formula using regular herd milk and fifty alternate babies on the same formula but using milk in which the curd was modified by the base exchange treatment. The babies of the series that are not accounted for in this table were at birth weight on the respective days.

	GAIN		LOSS	
	Curd modified	Regular	Curd modified	Regular
4th day	13	3	35	44
7th day	20	7	22	37
10th day	31	17	16	25

CONCLUSIONS

1. Cow's milk with zero curd tension* is superior to ordinary cow's milk for complemental feeding.

2. Milk treated by the base exchange process is superior to acidulated milk for complemental feeding and such milk is commercially available at practically the price of untreated milk.

3. In addition to the above tabulated findings, which in each instance show superiority of curd modified milk in producing gain and minimizing loss in the new born, we also found the base exchange modified milk to be applicable to a higher percentage of babies without the necessity of ordering a special formula. In short the curd modified milk was more suitable for a routine formula.

4. Constipation and regurgitation were materially lessened.

*The curd modified milk used in this experiment had a curd tension of zero.

— OSMJ —

A study of 3000 members of families and 1800 college students by the U. S. Public Health Service shows that colds are no respecter of sex. However in the matter of age colds cause least trouble to adults in their twenties and thirties.

A Simple and Safe Way to Establish Suprapubic Drainage

By CARL E. EVANS, M.D., F.A.C.S.,
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The following is a simple method of establishing suprapubic drainage in the many cases in which it is impossible to introduce an indwelling catherer through the urethra because of obstruction due to enormous prostate, adenoma, or inflammatory swelling of the gland.

Under such conditions, some sort of suprapubic drainage is imperative. The usual first stage cystostomy has been generally employed, but with marked arteriosclerosis the usual high N.P.N. and low P.S.P. there is great danger of creating a negative pressure on the kidneys with resulting anuria, uremia and death, when too rapid bladder drainage is established.

The simple procedure which can be controlled as accurately as an indwelling catheter and which is equally as safe is as follows:

Prepare suprapubic region same as for operation. Infiltrate tissues with ½ of 1 per cent solution of novocain.

With small knife incise the skin above space of Retzius for about 1/6 inch in length, thrust straight trocar into bladder, remove trocar, leaving cannula temporarily in bladder. Insert soft rubber catheter through cannula which is in bladder, gently pushing catheter well into bladder, gradually pull cannula out of bladder, slipping it over rubber catheter which has been cut off on distal end. The tissues fit snugly around catheter holding it firmly in place, but catheter can be retained by suture or safety pin with adhesive strips.

This method of drainage is applicable when it is impossible to introduce an indwelling catheter through the urethra.

— OSMJ —

Steuer Award to Clevelander

Dr. T. Wingate Todd, professor of anatomy, School of Medicine, Western Reserve University, has announced award of the Dr. Herbert S. Steuer Memorial Award for Work in Anatomy to George Robert Krause, Cleveland Heights, a junior.

During 1932 Krause assisted Dr. Todd in the technical assessment of *X*-ray studies of growing children, in the Brush Inquiry, and, after this training and experience, was assigned, in 1933-34, an investigation of growth in the guinea pig, again based on *X*-ray studies. Krause's contribution to this work was an elaboration, under the direction of Dr. T. T. Zuck, of a maturity scale for the growing pig. It required more than 30,000 estimations and their evaluation. The importance of this scale lies in its indispensability for precise measurement of the effects of experimental modification of animal growth.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

"In essentials, unity; in non-essentials, liberty; and in all things, charity." This quotation constituted the closing words of my inaugural address. Unity in essentials is emphasized rightly as a necessity for the success in organized effort.

The spirit of unrest and dissatisfaction with a resultant desire for change in the general social order and the concept of the functions of government unfortunately has become manifest within the medical profession. The contagion has spread from the social theorists and some physicians suffer from a severe infection. Obviously the social order in which we are living is undergoing rapid changes. In increasing number, magazine articles and pronouncements from certain organized groups attempt to prove that the medical profession is out of step with these changes.

Certain destructive forces would like to see the medical profession split asunder. As one observer has recently stated, "In our own medical societies in this country there are forces at work which are destructive rather than constructive. If we are to progress further in our organized medical program we must have unity. An essential of the code of that program must be unselfishness. If we have differences of opinion they must be ironed out among ourselves. Our discussion must not become the property of the public if we are to avoid that chaos that comes from incomplete information." Public evidence of apparent medical strife furnishes impetus and adds encouragement to many social movements inimical to scientific medicine and proper public service.

With the need for unity in essentials, it is surprising that a few members of our profession have joined with those endeavoring to obstruct and hamper the functioning of medical organization in its efforts to serve best the entire profession. It is deplorable, because our efforts should be spent in keeping the enemy from our walls and not in putting down sedition.

The hostility and shortsightedness of the few physicians who have launched unwarranted attacks on the policies and activities of organized medicine are understood by those personally acquainted with them. Many of these obstructionists have contributed little, if any, of their time or interest to any of the activities of organized medicine. Few of them have cooperated in constructive efforts. All too frequently they are poorly informed as to organization's activities and the problems confronting it. Some merely seek notoriety, while others grasp at the opportunity of denouncing organization policies merely as a means of retaliation against certain colleagues for personal grievances, frequently of imaginary nature.

In evaluating the diatribes of those obviously out of step with organization policy, it would be well to examine their records and see exactly what they have contributed to the upbuilding of the organization. Often enquiry will disclose the fact that the objectors have attended meetings only intermittently, perhaps even have allowed their membership to lapse from time to time, have failed to render faithful and consistent service as officers or on committees, and have contributed little or nothing which entailed sacrifice to upbuilding of the organization which they now in the hour of trouble would destroy.

The strength of medical organization as well as the effectiveness of its programs and undertakings, are in direct proportion to the interest and support accorded it by individual physicians working together.

Every member of medical organization who contributes interest and cooperation has a right to expect from the organization something in return. Few will deny that medical organization has conferred upon its members inestimable benefits over a period of many years. Moreover, every member is accorded the right to have a voice in the activities of the organization and the privilege of offering at any time constructive suggestions for improving its efficiency and effectiveness. Such criticism is the leaven in the loaf of organized medicine and is one of the reasons for its growth and improvement.

However, to the obstructionist, destructionist, publicity-seeker and the slacker, medical organization owes nothing. Criticism for the purpose of hindering or preventing medical organization from functioning in a dignified effective way that will be of advantage to every physician, or made merely to satisfy personal animosity, can have no beneficial effect either to him who gives or to those who receive. No possible good can be accomplished by crippling or destroying the very thing that has contributed greatly to the elevation of public health and medical standards and for years has safeguarded the interest of the individual physician.

Constant improvement in the effectiveness of organized medicine is to be desired and labored for. It cannot be achieved by undermining the whole structure of medical organization which would be the result of any campaign of vituperation designed to create dissension and dissatisfaction. Medical organization needs constructive criticism; it will thrive on concrete suggestions for its improvement; but it can be made impotent by wranging over non-essentials and by efforts designed to disrupt the orderly function of organization machinery.

POLICIES REGARDING SERIOUS ECONOMIC AND ETHICAL QUESTIONS ADOPTED BY A.M.A. AT WELL-ATTENDED CLEVELAND SESSION

In many respects the Eighty-Fifth Annual Session of the American Medical Association held in Cleveland, June 11-15, will go down in history as one of the greatest medical assemblies ever held in this country, demonstrating again the leadership that organized medicine is taking in the advancement of scientific medicine and in efforts to solve the serious and complex problems affecting medical practice and the economic status of the medical profession as a whole.

Particularly in the deliberations of the House of Delegates, the present-day economic and ethical questions directly affecting medical practice were given more extensive consideration than at any previous meeting, attesting to the seriousness of recent social and governmental changes from the standpoint of medicine and the medical profession.

The action of the House of Delegates in granting practically unlimited opportunity for a discussion of these important questions, in devoting much studious consideration to all angles of them, and in definitely establishing policies and procedure to guide the profession in meeting them as they arise, demonstrated conclusively that medical organization is thoroughly aware of and keenly appreciates the seriousness of the situation confronting the profession; that those chosen by the profession to represent it in these important matters are constantly devoting earnest and thoughtful consideration to them and are conscientiously attempting to represent the best interests of the profession as a whole; and are not disposed to compromise with those within or outside the profession on basic principles and policies that are deemed essential to safeguard the health and welfare of the public and preserve the independence and professional status of the medical profession, but are seeking methods of solving recognized problems in a sane, constructive and practicable manner.

From the standpoint of attendance the Cleveland session furnished a mark that will be difficult for future A.M.A. sessions to equal. Registration for the first four days of the meeting was 6,111.

LOCAL DETAILS HANDLED ADMIRABLY

The scientific programs and exhibits were exceptional from the standpoint of quality, variety and educational value, attesting to the importance of an annual session of the A.M.A. as an opportunity for post-graduate training in all phases of medical practice.

One of the remarkable things about the Cleveland session and one that aroused much favorable comment from those in attendance was the systematic smoothness with which the organization handling innumerable local details in connection with the meeting functioned. Members of the Cleveland Academy of Medicine who labored long and effectively under the able direction of Dr. C. W. Stone, general chairman of the committees on local arrangments, may rightfully be proud of their record. Due to the efficient work of each committee and each committeeman, all events were run-off according to schedule and everything possible was done to make the stay of the visiting physicians in Cleveland an enjoyable occasion. The hospitality of Cleveland physicians, as well as the city as a whole, permeated the entire meeting and contributed much to the outstanding success of the gathering.

The medical profession of Ohio in keeping with the occasion and with its splendid record as a criterion played a leading part in all phases of the session.

As was to be expected, the Ohio registration was considerably larger than that of any other state and even exceeded the expectations of those who had made pre-session predictions on attendance figures. The total number of Ohio physicians registered during Monday, Tuesday, Wednesday and Thursday was 2,081. This outpouring of Ohio physicians indicated the enthusiasm and interest of the medical profession of this state in matters of scientific advancement and in the activities of organized medicine. At the same time, the splendid attendance from Ohio was of material assistance to the Cleveland profession in the role of host.

OHIO PHYSICIANS WIN SCIENTIFIC AWARDS

Between 125 and 150 Ohio physicians took part in the scientific programs and in the Scientific Exhibit, the names of whom were published in the June issue of *The Journal*, pages 384 and 385.

A number of Ohio physicians were winners of high awards for their entries in the Scientific Exhibit.

Dr. Charles C. Higgins, Cleveland, was winner of the bronze medal in Class No. 1 in which awards were made for exhibits of individual investigations, judged on the basis of originality and excellence of presentation. Dr. Higgins had entered an original work on experimental production and solution of urinary calculi.

In Class No. 2 which included exhibits that do not exemplify purely experimental studies and

were judged on the basis of excellence of correlating facts and excellence of presentation. Dr. Claude S. Beck, Cleveland, won the silver medal for his exhibit illustrating circulatory failure produced by compression of the heart and curable by operation. A certificate of merit in this class was won by Dr. Russell L. Haden, Cleveland, for his exhibit illustrating the examination of the blood. Honorable mention was given to the exhibit of Dr. Wallace B. Hamby and Dr. W. James Gardner, Cleveland, on intracranial neoplasms.

Special commendation was given by the Committee on Scientific Awards to the groups of exhibits on growth and repair by the Department of Anatomy, Western Reserve University and the exhibit on biochemical diagnostic methods by Drs. Victor C. Myers, E. Muntwyler, F. C. Bing, R. F. Hanzel and C. T. Way, Cleveland.

OHIO'S WELCOME TENDERED VISITORS

Ohio hospitality was demonstrated on innumerable occasions during the entire week at luncheons and dinners arranged by fraternities, clubs, medical schools, special societies, etc. On two occasions the official welcome of the medical profession of Ohio to the visiting physicians was extended. The first was the formal dinner given jointly on Monday evening, June 11, at the Union Club by the Cleveland Academy of Medicine and the Ohio State Medical Association for the general officers and members of the House of Delegates of the American Medical Association. The second was the general session, held on the evening of June 12, the opening exercises of which consisted of addresses by Dr. C. L. Cummer, Cleveland, president of the State Association; Dr. A. A. Jenkins, Cleveland, president of the Cleveland Academy of Medicine and the Hon. Harry L. Davis, mayor of Cleveland. Following the installation of Dr. Walter L. Bierring, Des Moines, Iowa, as president of the A.M.A. at this opening general session, Dr. J. H. J. Upham, Columbus, chairman of the Board of Trustees of the A.M.A. presented the medal of appreciation to Dr. Dean Lewis, Baltimore, retiring president of the A.M.A.

Ohio took an especially important and conspicuous part in the transactions of the House of Delegates and was represented 100 per cent at each session of the House.

The Ohio delegation, consisting of Drs. Ben R. McClellan, Xenia, Wells Teachnor, Sr., Columbus, E. R. Brush, Zanesville, C. W. Stone, Cleveland, J. P. DeWitt, Canton, C. E. Kiely, Cincinnati, and C. W. Waggoner, Toledo, caucused frequently under the chairmanship of Dr. McClellan to discuss important questions pending before the House of Delegates and to determine the attitude of the delegation toward them, basing their decisions on the policies of medical organization in Ohio as established by the House of Delegates of the State Association.

NAMED ON IMPORTANT COMMITTEES

Two members of the Ohio delegation served on two of the most important reference committees of the House of Delegates, namely: Dr. Teachnor on the Reference Committee on Reports of Officers, and Dr. Waggoner on the Reference Committee on Legislation and Public Relations.

Dr. Upham, as chairman of the Board of Trustees of the A.M.A., presented to the House of Delegates the important report of the Board on its activities during the past year and frequently during the sessions of the House of Delegates reported the trustees' decisions and recommendations on matters of new business referred to the Board by the House of Delegates, among them some of the most important questions the delegates were called upon to consider.

Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council of the A.M.A. in addition to presenting the comprehensive and important annual report of the Judicial Council, appeared frequently before the House of Delegates to submit supplementary reports on questions of a judicial and ethical nature referred by the House to it for study and recommendation.

CLINIC PUBLICITY QUESTION AIRED

The question of unethical and unprofessional practices by clinics, institutions and groups of physicians was thoroughly analyzed in a supplemental report of the Judicial Council presented by Dr. Follansbee. The report referred to the constant and repeated demands being made from various communities for rectification concerning the publicity that attaches to some institutions, clinics and groups of individuals and alleged unethical practices by them.

Practices of clinics, institutions and groups in engineering and seeking publicity designed to obtain business or to represent to the public that the service rendered by them is superior to that of other similar organizations or individual physicians was condemned in the report, as well as other types of unethical and unprofessional practices used to focus public attention. The report emphatically pointed out that "there is but one code of ethics for all, be they group, clinic or individual and be they great and prominent or small and unknown". Moreover, the report stressed that "it is but a principle of sound ethics that the greater or more prominent an individual or a group may be the more scrupulous should be the observance of the principles of ethics by them". At the same time, the Judicial Council stated that it is neither a legislating body nor a prosecuting board; and that legislation on such questions rests with the houses of delegates of the A.M.A. and the various state associations and

prosecution with the individual county medical societies.

The report of the Judicial Council on these questions clarified and emphasized the points raised in a resolution presented to the House of Delegates by Dr. McClellan, chairman of the Ohio delegation, at the request of the Council of the Ohio State Medical Association (minutes of March, 1934, meeting of The Council, page 239, April issue of *The Journal*), and in effect upheld and amplified the sentiments expressed in that resolution.

COLLEGE OF SURGEONS BOARD CRITICIZED

Another report of the Judicial Council presented by Dr. Follansbee concerned a resolution presented by Dr. C. J. Whalen, Illinois, condemning the board of regents of the Americal College of Surgeons for recently approving a pre-payment plan of health insurance and calling upon the board of regents to explain their action to the American Medical Association. The report supported the sentiments expressed in the resolution and condemned as ill-advised and against sound public policy the action of the governing board of the College of Surgeons, which is not in accord with the policy of the American Medical Association on the question of health insurance and adds confusion to the present situation.

Dr. Follansbee in behalf of the Judicial Council also presented several amendments to the Principles of Ethics of the American Medical Association clarifying the definition of contract practice and strengthening sections of the Principles of Ethics relating to institutions and groups engaged in the care of the sick.

POLICY ON SOCIALIZED MEDICINE ADOPTED

As anticipated the questions of socialized medicine, government-controlled medical service, and sickness insurance were subjected to thorough study and analysis by various committees of the House of Delegates and by the House of Delegates itself during a four-hour executive session. Every attempt was made to give these important questions constructive as well as extensive consideration in order that policies and procedures might be established to guide the profession. A large amount of data compiled over a period of years on the subjects was presented and a complete summary of the policies of the American Medical Association to date toward them submitted to the House of Delegates by Dr. Upham for the Board of Trustees.

After lengthy study and discussion, the House of Delegates adopted as the official policy of the American Medical Association a declaration that any and all proposals for changes in medical practice must, in the interests of the public and the medical profession, conform to the following 10 principles:

1. All features of medical service shall be in the control of the profession.
2. No third party must be permitted to come between physician and patient in any medical relation.
3. Patients must have absolute free choice of physician.
4. Method of service must retain a permanent and confidential relation between patient and physician.
5. All medical phases of all institutions involved in medical service shall be under the control of the medical profession.
6. However the costs of medical service is distributed, the immediate cost must be borne by the patient able to pay at the time the service is rendered.
7. Medical service must have no connection with cash benefits.
8. Any form of service should include all qualified physicians of the locality who wish to serve under the conditions established.
9. Relief of low income classes shall be strictly limited to those below the "comfort level" of income.
10. There should be no restrictions on treatment or prescribing which are not formulated by the organized medical profession.

OTHER ACTIONS OF THE HOUSE OF DELEGATES

Other actions of the House of Delegates included:

Requesting the Board of Trustees to confer frequently with the representatives of other national organizations with a view to ascertaining their opinions on the economic problems of direct interest to the medical profession and to acquaint them with organized medicine's views on these questions.

Criticizing improper and harmful medical and drug advertising over the radio and requesting the Federal Government to establish regulations that would require professional and scientific approval of such advertising before it is broadcast.

Instructing the Council on Medical Education and Hospitals to refuse approval of hospitals for intern training unless the staff members of such hospitals are members of their local medical society.

Protesting hospitalization at the expense of the Federal Government of veterans suffering from non service-connected disabilities and free medical service furnished by government facilities at Washington to government officials and employes and the members of Congress.

Authorizing the Council on Medical Education and Hospitals to liberalize its standards regarding certification of specialists by requiring applicants for certificates from special boards to pass examinations only in that particular branch in which they are specializing.

Refused to authorize the appointment of a special committee to study the questions of birth control and contraceptives.

The detailed official minutes of the transactions

of the House of Delegates were published in the June 23 issue of *The Journal of the American Medical Association*. Every physician should read and study carefully these transactions dealing as they do with practically all of the serious questions confronting the profession, in order that he may thoroughly understand all phases of them and acquaint himself with the policies of medical organization regarding them. As suggested repeatedly on the floor of the House of Delegates, the officers and committees of county medical societies should provoke discussion on these questions at meetings of their respective societies, arrange for reviews of the action of the House of Delegates at the Cleveland session, and use the principles and policies evolved at that session as the basis for their attitude and action on local questions that affect in any way medical practice.

McLESTER NAMED PRESIDENT-ELECT

At the closing session of the House of Delegates, the following officers for the ensuing year were elected: President-elect, Dr. James S. McLester, Birmingham, Alabama; vice president, Dr. George G. Reinle, Oakland, California; secretary, Dr. Olin West, Chicago; treasurer, Dr. Herman L. Kretschmer, Chicago; speaker of the House of Delegates, Dr. Frederick C. Warnshuis, Grand Rapids, Michigan; vice speaker, Dr. Nathan B. Van Etten, New York City, and members of the Board of Trustees, Dr. Allen H. Bunce, Atlanta, Georgia, to succeed himself, and Dr. Roger I. Lee, Boston, to succeed Dr. D. Chester Brown, Danbury, Connecticut, retired.

Dr. McLester, the president-elect, is professor of medicine, University of Alabama School of Medicine and a former member of the Council on Medical Education and Hospitals, American Medical Association. He was a lieutenant colonel overseas during the World War and is nationally known for research dealing with metabolism and nutrition. He has been active in medical organization for many years and holds fellowship in the American College of Physicians and membership in many important special societies.

The following appointments were announced by Dr. Bierring, the president, and approved by the House of Delegates: Dr. Emmett P. North, St. Louis, member of Judicial Council, succeeding Dr. James B. Herrick, Chicago; Dr. John H. Musser, New Orleans, member of the Council on Medical Education and Hospitals, succeeding Dr. North, and Dr. Fred Moore, Des Moines, Iowa, succeeding Dr. McLester; Dr. C. C. Sturgis, Ann Arbor, Michigan, and Dr. Irvin Abell, Louisville, Kentucky, to succeed themselves on the Council on Scientific Assembly.

By a uninamious vote, the House of Delegates selected Atlantic City as the site for the 1935 session of the A.M.A.

Dr. R. B. Bretz, Cleveland, served as a delegate representing the United States Army and three Ohio physicians were members of official bodies that presented reports to the House of Delegates, namely: Dr. Torald Sollmann and Dr. H. N. Cole, Cleveland, members of the Council on Pharmacy and Chemistry, and Dr. Howard T. Karsner, Cleveland, member of the Council on Physical Therapy.

ENTERTAINMENT FOR WOMEN LAUDED

An exceptionally fine program of entertainment for the large number of women guests in Cleveland for the session was carried out under the direction of Mrs. Clyde L. Cummer, general chairman of the sub-committee on women's entertainment, and Mrs. Howard T. Karsner, chairman of the sub-committee on hospitality. This included a luncheon and bridge party at the Lake Shore Hotel, style shows, motor trips, musicales, golf, visit to shops and stores, tours of some of Cleveland's beautiful gardens, parks, and museums, formal banquet, etc. The home of Dr. and Mrs. Follansbee was open during the week to visiting women guests, who enjoyed their nationally famous collection of Americana.

This phase of the Cleveland program was carried out just as efficiently as all others and won for the Cleveland hostesses much praise and many compliments from the visiting women.

Among the special luncheons and dinners given during the week was the reunion dinner of the medical graduates of the College of Medicine, Ohio State University, given on Wednesday evening at the Hotel Hollenden under the direction of Dr. Russell G. Means, Columbus. Dr. Floyd S. Meck, Cleveland, presided as toastmaster. Talks were made by Dr. Upham, dean of the college, and John B. Fullen, secretary of the Ohio State University Alumni Association. Football movies were shown by Ernie Godfrey, assistant Ohio State football coach. About 200 attended.

Ohio physicians did well in the annual tournament of the American Medical Golf Association, held Monday at the Mayfield Country Club. The winner of the championship was Dr. John P. Loudon, Yakima, Washington, with a grand total of 152 for the 72-hole championship round. Ohio physicians who finished well toward the top in the championship event were: Dr. R. P. Bell, Cleveland, 165; Dr. Louis Mark, Columbus, 169; Dr. J. J. Marek, Cleveland, 169; Dr. R. H. Birge, Cleveland, 170; Dr. F. M. Casto, Cleveland, 170; Dr. J. D. Fouts, Dayton, 171; Dr. F. T. Gallagher, Cleveland, 172; Dr. W. A. Welsh, Youngstown, 173; Dr. A. V. Boysen, Cleveland, 174; Dr. D. C. Brennan, Akron, 177, and Dr. H. M. Schuffell, Canton, 178.

At the annual banquet of the golfing association, Dr. Charles Lukens, Toledo, was elected president for 1934-35.

NEW PLAN CONTEMPLATES PAYMENT MONTHLY OF MEDICAL BILLS UNDER STATE RELIEF ADMINISTRATION PROGRAM FOR FINANCIAL REVISION

Some of the financial difficulties that have arisen in many counties in connection with the plan of providing medical care in the home to the recipients of unemployment relief may be modified by a recent ruling of the State Relief Commission that each time a County Relief Director authorizes medical care he must encumber funds out of the county's $1 per family per month allowance for medical care to meet the costs of such service.

Detailed instructions to County Relief Directors relative to authorizing and encumbering funds for medical care to the needy were issued by the State Relief Commission on June 1 and incorporated in a revised edition of Supplement No. 1 to Rules and Regulations No. 7 of the Federal Emergency Relief Administration.

No changes were made in the revised medical fee schedule which became effective last March or in the policies and general rules governing the medical relief program.

The requirement that funds be encumbered when medical care is authorized, it is believed, should enable most counties to pay physicians' fees in full as it will prevent county relief administrations from using all or a part of their budgetary allowance for medical care for other types of relief. That has been done in some counties with the result that little if any money has been available for paying physicians for necessary and authorized medical services.

However, under these regulations, in case the total amount of money encumbered under the recent ruling exceeds the budgetary allowance of $1 per month per family on the relief rolls, it will be necessary for the County Relief Director to pro rate the payment of bills for medical care.

Each county is entitled to $1 per month per family on relief for medical services and it is the responsibility of each County Relief Director to see that such an amount is included in the budgetary requests submitted monthly to the State Relief Commission.

PRINCIPLE FEATURES OF NEW PROCEDURE

Some directors have failed to request a sum equal to this allowance for medical care. In counties where this has occurred, representatives of the county medical society should contact the County Relief Director and insist that the maximum sum be requested to insure more adequate funds for the county's medical relief program.

Some of the important provisions of the new procedure pertaining to authorizing and encumbering funds for medical care are:

1. The use of one new form—SRC 729—will be required. This form, to be filled in by the County Relief Director, records the costs in each case of authorized medical care and encumbers funds to meet these costs. The use of Form RM or RO will be continued, these forms being in effect an invoice of each case for which medical care has been authorized.

2. The County Relief Director or an authorizing agent appointed by him will be required to fill in most of the data requested on all medical forms, relieving the physician from much detailed paper work.

3. All medical bills will be paid once a month, on or about the 10th of each month, for services rendered during the preceding month, and all dates of visits by a physician on any one itemized statement must be of the same month. *Physicians will be required to comply with the provision that itemized fee bills (Form RM or RO) be submitted after five or less visits and within five days after the date of the last visit.* The County Relief Director will be expected to determine on the last day of each month the total cost of medical care in his county for the month preceding. *These requirements make it very important that each physician submit his fee bills promptly.* Unless bills for medical services are received promptly by the County Relief Administration, the director will be handicapped in making out his requisition for funds and difficulty will be encountered in the plan to pay all medical bills on the 10th of each month.

4. If in any one case all visits authorized during a given month are not completed by the last of the same month, a new set of authorization blanks (SRC 729 and Form RM or RO) will be necessary to comply with the ruling that all dates of visits on any one invoice (RM or RO) must be within the same month.

HOW AUTHORIZATION IS OBTAINED

Following is a detailed description of the procedure which should be followed by the County Relief Administration and physicians, based on the rules and regulations in Supplement No. 1 (Revised) dated June 1, 1934:

When a family on the relief rolls requires medical care, contact must be established with the County Relief Director or his authorizing agent to obtain an authorization for medical care

and permission to select a physician from the registered list of physicians at the county relief headquarters.

Only in cases of emergency will families be permitted to call a physician before securing a medical order blank from the County Relief Administration, and then in each case an order must be secured before the second visit of the physician.

When medical, dental or nursing care is requested and authorized, the local relief director or his authorization agent will issue a set of Forms SRC 729 and RM or RO and will fill in the upper part of pages 1, 2 and 3 of RM or RO, crossing out two of the three degrees, M.D., D.D.S., and R.N., leaving the proper degree to follow the name of the doctor, dentist or nurse.

If authorization is for less than five visits, the number of visits authorized should be indicated in the proper place. The fee for each visit and the mileage allowance should be entered in the Itemized Statement on RM or RO by the authorization officer.

The authorization agent should check the type of care authorized, being sure to state the name of the physician recommending nursing care. Subsequent authorizations in writing, by telephone, or verbally should be recorded in the proper space of pages 1, 2 and 3 of RM or RO.

HANDLING OF FORMS OUTLINED

Page 1 (yellow) of Form RM or RO should be retained by the local relief administration. Pages 2 and 3 (white) of these forms should be sent to the physician, dentist or nurse on the case.

The yellow SRC 729 card is to be retained by the local relief administration. The white card of this form is to be sent to the physician with every item except "dollars and cents" filled in by the authorization agent. The blue card of SRC 729 is to be sent to the auditor of the State Relief Commission.

If all the visits authorized in the case are not completed during the month, the local relief administration will be required to issue a new set of SRC 729 and RM or RO blanks.

If the case is discharged, sent to a hospital, or deceased, the physician or nurse should check the proper space and return page 2 of RM or RO to the local relief administration within five days after the date of the last visit shown in the Itemized Statement. Page 3 should be retained by the physician or nurse for his or her records.

EXTENSION OF TIME MAY BE GRANTED

If the case needs further care at the end of five visits (or the number authorized) the physician should request an extension of time. If the extension is granted by the authorization agent, he should issue a new set of forms to cover the extended time.

Should the case need the services of a specialist or nurse, the physician in charge should communicate with the local relief administration recommending the same. The administration then will be responsible for authorization. When a specialist or nurse is authorized, a record is to be made in the space provided on pages 2 and 3 of RM or RO.

When special drugs or supplies are needed, the physician should describe the same in the space provided on pages 2 and 3 of RM or RO and notify the local relief administration (in writing, by telephone, or verbally) of the need for such supplies. Then, it will be up to the relief administration to authorize the purchase of such drugs or supplies and, where practicable, deliver them. If special drugs or supplies are furnished by the physician their cost should be entered in the proper space on the Itemized Statement on RM or RO.

BILLS TO BE PAID ON 10TH OF MONTH

All medical costs authorized in connection with the case are recorded by the local relief administration on SRC 729 and funds to meet them are automatically encumbered. At the end of the month, the County Relief Director is required to total all the SRC 729 cards for that month. If the total cost of medical care in the county for that month does not exceed $1 per family on relief, each encumbered fee bill will be paid in full on the 10th of the following month. If the amount encumbered exceeds the $1 per family per month limit, the budgetary amount will be pro rated among those who have submitted fee bills.

Officials of the State Relief Commission believe that pro rating of medical bills will be unnecessary in most counties if the new authorization and encumbering procedure is handled in an efficient manner by the local relief administrations.

SEVERAL ADVISORY COMMITTEES FORMED

Although the State Relief Commission has not as yet put into effect the plan under consideration for having established in each county a local medical advisory committee, as contemplated in Federal Rules and Regulations No. 7, such committees have been established in a number of counties by the local relief administration and are giving the local relief director effective assistance in handling the medical program in the respective counties.

Each County Relief Director can, if he chooses, establish such an advisory committee consisting of members of the county medical society to advise and assist him. Every county medical society should arrange a conference with the local relief director on this matter, pointing out to him the advantages of the plan and cooperating with him in formulating such a committee. Such a committee would be able to advise the director on difficult medical questions, assist in authoriza-

tion problems, and act as a contact unit between the County Relief Administration and the county medical society. In this manner the County Relief Director would be able to secure the cooperation of the county medical society in requiring compliance with the rules and regulations governing medical care to the needy and preventing one or a few physicians from overcharging or rendering excessive treatment which might force the pro rating of medical bills and work to the detriment of all physicians. On the other hand, through a local medical advisory committee the county medical society would be able to keep in close touch with the way the medical relief program is being administered and to submit from time to time recommendations and suggestions for improving the set-up.

Dr. A. H. Kimmel, who has been medical advisor to the State Relief Commission since last December, has resigned, effective June 1, to enter private practice at Norwalk. His successor is Dr. John B. Eckstorm, Columbus. Dr. Kimmel handled many of the details in connection with the medical relief program in the state and its administration. His cooperation and assistance were helpful to the officers and committees of the State Association in their contacts with the Commission and the solution of some of the serious problems which arose after the inauguration of the medical plan in Ohio. Before becoming advisor to the State Relief Commission, Dr. Kimmel had practiced at Cleveland and Toledo.

On June 1, the offices of the State Relief Commission at Columbus were moved from the Wyandotte Building to the Pure Oil Building, High and Chestnut Streets.

THREE HUNDRED TAKE EXAMINATIONS GIVEN BY STATE MEDICAL BOARD, JUNE 5-8; LIST OF QUESTIONS ASKED

Three hundred applicants for licenses to practice medicine and surgery and limited branches of medicine in Ohio took the written and practical examinations conducted in Columbus, June 5-8, by the State Medical Board.

Medical college graduates totaling 231 took the examinations in medicine and surgery. Others examined included: 22 osteopaths, 12 chiropractors, two electrotherapists, nine mechanotherapists, four chiropodists, seven cosmetictherapists, and 13 masseurs.

Results of the examination will be certified at the next meeting of the Board, scheduled for July 10.

Following are the questions asked in the medical and surgical examinations:

ANATOMY

1. Name the lobes and fissures of the cerebrum.
   Give the boundaries of the parietal lobe.
2. Describe the ankle joint.
   Name the ligaments, nerves and arteries of this joint.
3. Mention the bones entering into the formation of the nasal septum.
4. Locate the foramen lacerum posterius.
   What does it transmit?
5. On what muscles does the sacral plexus rest?
   How is it formed?

PHYSIOLOGY

1. Discuss acid base balance; its variations and control, with special reference to acidosis and alkalosis.
2. Diagram and label a normal electrocardiogram and state the significance of the various components.
3. Define—
   (a) Tidal air
   (b) Complemental air
   (c) Reserve air
   (d) Residual air
   (e) Vital capacity
4. Discuss the metabolism of fat.
5. List the five most important functions controlled by the anterior grey horn cells in the spinal cord.
6. Describe the physiological influences which may play a part in determining the daily quantity of urinary output.
7. Discuss venous pressure in cardiac failure.
8. Describe the effects of complete transection of the spinal cord at the level of the sixth cervical vertebra.
9. Describe what changes take place in the composition of the blood as it passes through kidneys.
10. Explain reciprocal innervation of muscles, giving an example.

DIAGNOSIS

1. Of what value is the leucoyte count in acute abdominal conditions? Discuss the shift.
2. Discuss briefly high and low blood pressure—their causes, their prognosis as to life.
3. How would you determine the cause of cyanosis in an emergency patient admitted to hospital?
4. Differentiate acute obstruction of respiratory organs; by foreign body and by acute enlargement of Thymus.
5. Describe in order the five important early signs in an acute case of appendicitis.
6. Discuss brain abscesses—the most frequent causes, their prognosis.
7. A patient recently convalescent from scarlet fever is seized with convulsion; how would you proceed to make a diagnosis?
8. A young woman is brought to the hospital, history of sharp excruciating pain left side of pelvis, fainting, rapid pulse and air hunger, pallor, leucoyte count of 50,000; make a diagnosis.
9. Differentiate between Tetany, Tetanus and overdose of strychnia.
10. A patient gives history of a recent injury to lower end of femur, followed by a slow tumor growth; how would you proceed to determine its type? Give differential prognosis.

CHEMISTRY

1. How many grams of pure potassium hydroxide are required for exactly one liter of normal alkali solution?
2. How is Fehling's solution made?
3. How would you determine between bismuth subnitrate and calomel?
4. Give five alkaloids and source of each.
5. Give antidotes for Phosphorus Poisoning.

MATERIA MEDICA

1. Name three bacterial vaccines.
   Give mode of administration and indication for use of each.
2. What is the common name of Magnesium Sulphate?
   Give its uses, proper dose and indications.
3. Give the physiological action and dose of caffeine.
4. Methenamine, U. S.—How is it obtained?
   Give its physiological action and dose.
5. Boric Acid—Give physiological action and therapeutic uses.

6. Name five remedies of value in the treatment of shock, giving dose and manner of administration.
7. Name three remedies useful in the treatment of vesical spasm, giving dose.
8. Prescribe for a case of stomatitis.
9. Classify and give doses of the following:

(a) Cascara Sagrada
(b) Calumba
(c) Hexylresorcinol
(d) Spiritus aethyl nitritis (U.S.P.)
(e) Ventriculin

10. Name five remedies advised in the treatment of hiccough, giving dose.

MATERIA MEDICA
(Homeopathic)

1. Differentiate: (a) Iodine (b) Bryonia, in pneumonia.
2. Name three remedies commonly used in acute nephritis.
3. Differentiate: (a) Digitalis (b) Cactus, in heart disease.
4. When would you prescribe Euphrasia in a coryza?
5. In what potency would you usually prescribe the following drugs:

(a) Gelsemium
(b) Lycopodium
(c) Tuberculinum
(d) Nux
(e) Silica
(f) Kali-sulph
(g) Spongia
(h) Aconite
(i) Natrum-mur
(j) Sulphur

6. What are the eye symptoms of Cinnabaris?
7. What are the symptoms of arsenicum in diarrhea?
8. From what sources are the following derived:

(a) Terebenth
(b) Sepia
(c) Hepar-sulph
(d) Carbo-vegetabilis
(e) Lycopodium
(f) Rama-bufo
(g) Lachesis

9. What are the indications for Strophantus?
10. What is the botanical name for Rus-Aromatica?

BACTERIOLOGY, PATHOLOGY & HYGIENE

1. What is meant by a virus disease. Give two illustrations.
2. What are the dangers of chronically infected tonsils?
3. What is meant by "spores" and what part do they play in bacterial activity and infection?
4. How would you detect blood in the stools not apparent to the naked eye, and name three conditions it might indicate.
5. Name five conditions which may cause enlarged cervical glands.
6. What is meant by metastasis in malignant tumors? Discuss routes and probable danger areas in (a) cancer of breast (b) cancer of uterine cervix.
7. What conditions may follow gonorrhea in the female, and give the route of infection.
8. Discuss the pathologic conditions which may follow varicose veins of the lower extremities.
9. What food deficiency is found when a child develops (a) rickets (b) scurvy
How may these conditions be prevented or overcome?
10. What are the qualities of a potable water, and name four characteristics, the presence of any one of which would cause you to condemn a water for drinking purposes?

PRACTICE

1. Give the symptoms of amoebic dysentery, mode of infection and treatment.
2. Discuss the etiology and symptoms of acute catarrhal jaundice; differentiate from epidemic jaundice and give treatment.
3. Give the objective and subjective symptoms of septic (epidemic) sore throat; differentiate it from early stage of scarlet fever and give treatment.
4. Discuss nervous indigestion and differentiate it from organic gastric disease.
5. Describe the course of an acute bronchitis and write a prescription for the second stage of an attack.
6. A man aged 55 complains of shortness of breath on moderate exertion, has a little edema of extremities at night; left cardiac border a little outside of nipple line, no murmurs; blood pressure 144 systolic and 105 diastolic. Discuss the diagnosis, prognosis and treatment.
7. Give the etiology, symptoms and treatment in cystitis in a female child of five years.
8. Give the symptoms of mumps, course of the disease, complications and treatment.
9. What is meant by aphasia and how would you differentiate between an organic and a functional cause in a given case?
10. Discuss your legal obligations in practice in relation to births, deaths, privileged communications in court actions in (a) civil (b) criminal cases.

SURGERY

1. Describe the common associated pathological condition frequently found in a patient suffering a fracture of the os-calcis.
2. Give the symptoms and pathological findings in a case of multiple myeloma for a period of three months, leading up to and including the death of the patient.
3. Describe the approach to a stone in the ureter of a male patient, located one inch above the bladder; omit the operative technique.
4. What pathological condition does a nystagmus in the vertical plane indicate?
5. Outline the treatment for a man 64 years old, with an exophalmic goiter having a metabolic rate of plus 70 and an aortic stenosis.
6. Upon what findings would you advise a Caesarian section?
7. Differentiate between acute Meckel's diverticulitis and obstruction of right urethra at brim of true pelvis. What operative approach would you consider best for the patient?
8. Given a closed lung abscess in the lower right lobe—outline operating treatment and how prevent contamination of pleural cavity.
9. Name three conditions of the leg requiring amputation. Where would you amputate in each? Why?
10. Discuss skull fractures with subdural compression; extra-dural compression. Give prognosis.

SPECIALTIES

1. What is the action and what is the usual strength of the following solutions as used in Ophthalmology:

(a) Cocain
(b) Esorine
(c) Boric Acid
(d) Holocain
(e) Nitrate of Silver
(f) Dionine
(g) Merthiolate
(h) Zinc Sulphate
(i) Atropine

2. Given a patient with acute mastoiditis, what information could be deduced by a knowledge of the shift in the blood count?
3. Name three tests that are commonly used in making a diagnosis of deafness.
4. In a case where ligation of the right cartoid artery is necessary, give a complete description of the collateral circulation.
5. What do you understand by the term "physiological nystagmus"?

OBSTETRICS

1. Name the sutures of the fetal head. Of what use are they in diagnosing the presentation?
2. What precaution should be taken against infection during labor?
3. How would you prevent perineal tears during labor and delivery?
4. Give the treatment of excessive vomiting in pregnancy.
5. Under what circumstances are anesthetics indicated in labor? What are the dangers?

— OSMJ —

Dr. Alfred Friedlander New Dean of Cincinnati Medical College

Dr. Alfred Friedlander, Cincinnati, a graduate of the Medical College of Ohio and professor of medicine at the College of Medicine, University of Cincinnati since 1919, will become dean of the medical college on September 15 when the resignation of Dr. A. C. Bachmeyer becomes effective.

The appointment of Dr. Friedlander was made by the board of directors of the University by a unanimous vote following a recommendation made by the council of the medical college faculty.

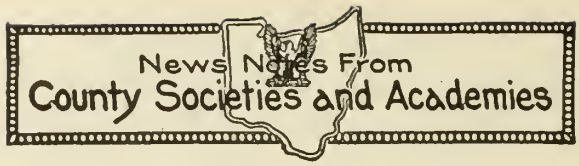
Dr. Bachmeyer, who had held the deanship since 1925, resigned several months ago to devote more time to administration of the Cincinnati General Hospital of which he is superintendent. He will continue his post as professor of hospital administration at the University.

— OSMJ —

Lorain—Dr. L. A. Stack has been appointed a member of the board of trustees of Pleasant View Sanatorium, succeeding Dr. W. E. Wheatley.

— OSMJ —

Athens—Dr. A. K. Buell, formerly of Columbus, has opened an office here.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(Harold F. Downing, M.D., Secretary)

At the annual meeting of the Academy of Medicine of Cincinnati, the following officers were elected for the ensuing year: President-elect, Dr. Edward D. King; secretary, Dr. H. J. Lavender; treasurer, Dr. Charles E. Hauser; trustee, Dr. Otto J. Seibert; delegates to State Association, Dr. Seibert and Dr. Louis J. Feid, Jr.; alternates, Dr. H. H. Shook and Dr. T. A. Ratliff. The new officers will be installed at the first Fall meeting, September 28, when Dr. John A. Caldwell, president-elect of the State Association, will be inducted into office as president of the Academy. Dr. L. Howard Schriver announced that the recommendations of the Academy for changes at the General Hospital had been accepted. A resolution was introduced by Dr. Ralph W. Good and left pending for action in the Fall, asking that the new dean of the College of Medicine, University of Cincinnati, confine his activities to the executive and professional duties in connection with the deanship.

Adams County Medical Society met on June 20 at the Court House, Batavia. An excellent program was presented by Dr. Parke G. Smith, Cincinnati, councilor of the First District; Dr. Otto Seibert, Cincinnati, and Dr. Carl Minning, Williamsburg. Dr. Smith presented a paper on "Anatomy of the Prostate, Mechanism of Prostate Obstruction and Present Status of Prostatic Surgery". Dr. Seibert spoke on "Cancer of the Breast", and Dr. Minning read a paper on "Notes on Gonorrhea in the Male".

At the May meeting of the society, held on May 16, Dr. Joseph Biederman and Dr. S. H. Portnoy, both of Cincinnati, addressed the society. Dr. Biederman spoke on "Allergy", and Dr. Portnoy on "Practical Eye, Ear, Nose and Throat Procedures for the General Practitioner".—Bulletin.

Highland County Medical Society was addressed on June 6 by Dr. Kelley Hale, Wilmington. Dr. Hale spoke on "Pelvic Apppendix".—News Clipping.

Second District

Darke County Medical Society met at Greenville on May 18. Following dinner, the society was addressed by Dr. Cecil Striker, Cincinnati, on "Treatment of Diabetes Mellitus".—Bulletin.

A special meeting of the society was held on May 24 when Dr. G. A. Woodhouse, secretary of the Miami County Medical Society, explained the set-up for the credit bureau now being operated successfully by his society. A committee was appointed to study the question of establishing such a bureau for members of the Darke County society.—Bulletin.

Miami and Shelby County Medical Societies held their annual joint meeting on June 7 at the Sidney Country Club. The guest speaker was Dr. C. L. Jones, Springfield, who spoke on "Angina Pectoris". Dinner was served and golf and other diversions enjoyed.—News Clipping.

Montgomery County Medical Society held its annual meeting and outing on June 1 at the Dayton Country Club. The following officers for the ensuing year were elected: President, Dr. A. G. Farmer; first vice president, Dr. B. F. Suffron; second vice president, Dr. H. C. Mundhenk; delegate to State Association, Dr. A. W. Carley; alternate, Dr. E. M. Smith; member of board of censors, Dr. A. W. McCally; legislative committeeman, Dr. Wester S. Smith. The guest speaker was Dr. Martin H. Fischer, Cincinnati, who spoke on "Art and Practice". A golf tournament was held preceding the dinner and program.—Bulletin.

A called meeting of the society was held June 5 for the purpose of hearing complaints of some members of the society relative to the legal and economic status of the Dayton Clinic; the professional activities of certain members of the clinic staff, and publicity concerning the clinic. Motions to sustain the charges for the purpose of expulsion or suspension were defeated. A motion to censure those against whom complaints had been made was carried.

Third District

Allen County—Academy of Medicine of Lima and Allen County met on May 22 at the District Tuberculosis Hospital near Lima. The guest speaker was Dr. Frank C. Anderson, Mt. Vernon, who spoke on "Tuberculosis in All Its Forms". The new hospital building was inspected and a social hour enjoyed following the program.—News Clipping.

Auglaize County Medical Society was entertained with a "Clinic Night" program at its meeting June 7 at St. Marys. Dr. I. D. Baxter, Lima, read a paper on "Acute Abdominal Surgical Conditions in Children" and presented cases on in-

tussusception and infantile appendicitis. Dr. Alfred W. Veit, Wapakoneta, reported two cases of "Hemorrhagic Pancreatitis", one recognized at operation which recovered; the other definitely diagnosed at autopsy. Dr. Robert G. Slusher, New Knoxville, was admitted to membership.—C. C. Berlin, M.D., Secretary.

Hardin County Medical Society met on May 17 at Kenton. The guest speaker was Dr. James R. Tillotson, Lima, who spoke on "Fractures". It was the last meeting of the society until Fall.—News Clipping.

Marion County—Marion Academy of Medicine had as its guest speaker on June 5, Dr. H. K. Shawan, Detroit. Dr. Shawan presented two lectures, one on "Cerebral Cranial Injuries" and one on "Toxic Goiter". A historical sketch on surgery was presented by Dr. C. G. Smith and case reports were reviewed by Dr. Floyd Yeager. —News Clipping.

Mercer County Medical Society held a dinner meeting May 10 and was addressed by Dr. B. L. Good, Van Wert, on "Pre-Surgical Treatment". —News Clipping.

Van Wert County Medical Society enjoyed a program on "The Inspirational Aspects of Medicine" at its meeting June 5. The program was presented by Dr. F. W. Duckwall, Dr. C. Mowery and Dr. S. A. Edwards.—Bulletin.

Fourth District

Putnam County Medical Society held a dinner meeting June 5 at the DuMont Hotel, Ottawa. Wives of the members were guests. Guest speakers were Dr. F. C. Anderson, Mt. Vernon, superintendent of the Ohio State Sanatorium, and Dr. O. E. Harvey, superintendent of the Lima District Tuberculosis Hospital.—News Clipping.

Sandusky County Medical Society held a dinner meeting June 19 in honor of Dr. C. R. Pontius, Fremont, who recently celebrated his 50th anniversary in medicine. The affair was arranged by Drs. E. M. Ickes and F. L. Moore.—News Clipping.

Wood County Medical Society in session May 17 at the Woman's Club, Bowling Green, was addressed by Dr. T. O. Whitacre and Drs. Harold P. Shapiro and William M. Shapiro, both of Toledo. Dr. Whitacre spoke on "*X*-ray in Private Practice". Dr. Harold P. Shapiro discussed "Aids to Surgery in the Home" and Dr. William Shapiro read a paper on "*X*-ray As An Aid to Diagnosis".—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(C. H. Heyman, M.D., Secretary)

June 7—Joint meeting of the Academy and the American Association for the Study of Goiter. Program: Address of welcome, Dr. A. A. Jenkins, president of the Academy; Presidential address, Dr. R. M. Howard; "Hypothyroidism Induced by Total Ablation of the Thyroid in Treating Patients with Chronic Heart Disease", Dr. H. L. Blumgart, Boston; "Psychoses in Hypothyroidism and Hyperthyroidism", Dr. L. J. Karnosh, Cleveland.

June 8—Joint meeting of the Academy and the American Therapeutic Society. Program: "Surgery of the Pericardial Scar", Dr. Claude S. Beck, Cleveland; "The Treatment of Carcinoma of the Colon", Dr. W. W. Babcock, Philadelphia; "Causes of Sudden Death", Dr. A. R. Moritz, Cleveland; "Intracardial Therapy for Resuscitation of the Stopped Heart with Demonstrations of the Artificial Pacemaker", Dr. Albert S. Hyman, New York.

Geauga County Medical Society in session May 24 was addressed by Dr. Fred Dixon, Cleveland, on "Mastoiditis and Middle Ear Infection".—News Clipping.

Huron County Medical Society at its meeting May 16 at Memorial Hospital, Norwalk, was addressed by Dr. A. J. Skeel, Cleveland, on "Maternal Mortality" and Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, who discussed economic and organization questions.—News Clipping.

Lake County Medical Society met in regular session May 29 at the Lake County Memorial Hospital, Painesville. The guest speaker was Dr. Wallace Duncan, Cleveland, who spoke on "Low Back Disability". The address was illustrated with lantern slides.—Mabel L. Pearce, M.D., Secretary.

Sixth District

Mahoning County Medical Society in regular session June 19 at the Youngstown Club was addressed by Dr. Charles L. Brown, associate professor of medicine, University of Michigan, on "The Diagnostic Survey and Medical Management of Chronic Gall Bladder Disease".—Bulletin.

Seventh District

Belmont County Medical Society was entertained on May 31 at the Martins Ferry Hospital with motion pictures on "Operations for Inguinal Hernia, Low Forceps and Posterior Colporrhaphy".—Bulletin.

Eighth District

Athens County Medical Society met June 4 at Nelsonville. The guest speaker was Dr. P. D. Scofield, Columbus, who read a paper on "Spinal

Anesthesia". Luncheon was served preceding the program.—News Clipping.

Guernsey County Medical Society in session May 17 was addressed by Dr. F. J. Lacksen, Quaker City, on "Management of Diabetes".

On June 7, the society was addressed by Dr. B. K. Wiseman, Columbus, who discussed "Newest Methods in the Treatment of Blood Diseases".—News Clipping.

Muskingum County — Muskingum County Academy of Medicine and the Muskingum County Pharmaceutical Society held a joint meeting June 6 at the Washington Heights Hotel. The guest speaker was Dean Edward Spease, School of Pharmacy, Western Reserve University. Dean Spease discussed the plan of cooperation between physicians and pharmacists now in operation in Cleveland.—News Clipping.

Perry County Medical Society met in regular session May 21 at the Park Hotel, New Lexington. The principal address was made by Dr. J. Victor Greenebaum, Cincinnati, who spoke on "Rickets, Early Recognition, Its Prevention and Treatment".—News Clipping.

Ninth District

Hocking County Medical Society discussed various phases of the medical relief question at its meeting May 11. James R. Allen, county relief director, was present and took part in the discussion. Upon authorization of the society, an advisory committee was appointed to work with the county relief administration on medical matters. The committee is composed of Dr. H. M. Boocks, Dr. M. H. Cherrington, and Dr. W. B. Lacock, county health commissioner and authorization officer for the relief administration.—News Clipping.

Pike County Medical Society held a dinner meeting May 7 at the Emmitt House, Waverly. Following the dinner, a business session was held. —News Clipping.

Scioto County—Hempstead Academy of Medicine was addressed on June 11 by Dr. C. L. Ferguson on "Foot Disabilities". A buffet supper was served following the program.—Bulletin.

Tenth District

Crawford County Medical Society held its annual outing June 6 at the Bucyrus Country Club. Many physicians from adjoining counties attended. Following the golf tournament in the afternoon, a grilled steak dinner was served.—News Clipping.

Pickaway County Medical Society was addressed on May 11 by Dr. W. E. Masters and Dr. H. E. Boucher, both of Columbus. They discussed various phases of diabetes.—News Clipping.

Big Decline Registered in Birth Rate of Foreign-Born in Ohio in 1933

The lowest birth rate ever recorded in Ohio since the establishment of registration in 1908 was last year when it dropped to 13.8 per 1,000 population, according to *The Ohio Health News*, State Department of Health publication. The state's birth rate has declined 30 per cent since 1910. The peak year in the registration of births was in 1924, when 132,048 records were filed in the State Department of Health, Division of Vital Statistics, and since then the decline has been very definite, with 94.6 per cent of the decrease in the number recorded last year in the cities, and only 5.4 per cent in the rural districts.

One of the greatest declines in birth registration was among children of foreign-born mothers. During the past 23 years Ohio's birth rate for children to foreign born mothers declined 39 per cent, as compared with a decline of only 9.9 per cent in the native birth rate.

In 1910, 81.8 per cent of all the birth records filed was for children of native mothers, the other 18.2 per cent was for children of foreign born mothers. Last year the native mothers gave birth to 92 per cent of all children born in the State, and children to foreign born mothers decreased to only 8 per cent of all records filed.

Negro mothers gave birth to 2 per cent of all children born in 1910; in 1920 this number decreased to 1.2 per cent; in 1930 increased to 5.2 per cent, but since 1931 there has been no increase in the number of negro births, which is 5.3 per cent of all children born.

Mothers natives of Ireland are the only foreign born to show an increase in the birth rate. In 1910 it was 14.4 and in 1930 16.3 per 1000 population. From 1920 to 1930 the birth rate increased for children born to mothers natives of Denmark, Norway, Sweden and Germany. However, 1930 showed a decrease from the year 1910. The greatest decline in birth rate for children of foreign born mothers was from natives of Russia, Italy, Austria and Hungary.

Tabulated below is the number of births, with rates per 1000 population for children born to foreign born mothers for the years 1910, 1920 and 1930, the census years, with a more accurate population:

Country	1910 *No.*	1920 *No.*	1930 *No.*	1910 *Rate*	1920 *Rate*	1930 *Rate*
Austria & Hungary	5897	7612	2217	39.8	62.8	32.8
Canada	432	419	452	18.2	16.9	16.7
Den., Nor., Sweden	165	98	133	29.9	8.8	11.8
Eng., Scot., Wales	1239	1057	858	19.5	16.7	13.1
Ireland	578	505	375	14.4	17.2	16.3
Germany	3197	1087	894	19.4	9.1	9.3
Italy	2048	3865	2380	49.2	63.7	33.2
Poland	1395	3062	1143	33.5	45.2	17.7
Russia	1637	1765	579	61.5	40.4	17.7
France	61	157	67	12.6	19.4	11.4
Other Foreign	2025	3466	3170	51.6	47.8	69.7
Total Foreign	18474	23093	12168	30.8	33.9	18.8
Total Native	80442	97266	99233	19.2	19.7	17.3

Deaths in Ohio

Milton Monroe Bauer, M.D., Uniontown; Long Island College of Medicine, Brooklyn, New York, 1880; aged 81; member of the Ohio State Medical Association, and Fellow of the American Medical Association; died June 2 at Akron City Hospital. Dr. Bauer, one of the oldest practicing physicians in Stark County, had practiced in Uniontown for the past 55 years. He was a past president of the Sixth Councilor District Society and an honorary member of the Cleveland Academy of Medicine. Besides his widow, he is survived by a son and two brothers.

Thcodore Breck, M.D., Brecksville; Cleveland College of Physicians and Surgeons, 1894; aged 67; died June 13 of appendicitis. Dr. Breck had practiced in the village of his birth for the past 40 years. His widow and two sons survive.

John C. Buttemiller, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1877; aged 81; former member of the Ohio State Medical Association; died May 17. Dr. Buttemiller practiced in Cincinnati from 1877 until his retirement ten years ago. He was a former member of City Council, and Past Master of Hoffner Lodge of Masons. Surviving him are his widow, a son, Dr. George S. Buttemiller, and a daughter, Mrs. Marion Whitacre.

Newton R. Eastman, M.D., Mt. Vernon; Starling Medical College, Columbus, 1895; aged 63; former member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 16 of paralysis. Dr Eastman was a former president of the Baltimore and Ohio Railroad Surgeons Association. Two sons and one daughter survive.

William J. Esch, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1881; aged 73; died June 12 of heart disease. Dr. Esch was a native of Germany and was for many years house physician at Charity Hospital. His widow, three sons and six daughters survive.

Norman F. Jacobs, M.D., Kent; Michigan College of Medicine and Surgery, Detroit, 1900; aged 62; former member of the Ohio State Medical Association; died May 13, of heart disease. Dr. Jacob practiced at Whitehouse until 14 years ago when he moved to Kent. He was a member of the Knights of Pythias. His widow and two children survive him.

J. W. Keekler, Greenville; licensed, Ohio, 1896; aged 69; died May 9 following a long illness. Dr. Keckler practiced at Yorkshire until 1912 when he was appointed postmaster of Yorkshire. He moved to Greenville in 1922. Surviving him are one son, one brother and two sisters.

George W. Kirk, M.D., Curtice; Toledo Medical College, Toledo, 1888; aged 83; died June 1 following a long illness. Dr. Kirk had resided in Curtice for 50 years. A nephew and two nieces survive him.

Charles W. Mackenbach, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 66; died June 7 of cancer. He formerly practiced at Coldwater. One sister survives.

John B. May, M.D., New Holland; Cincinnati College of Medicine and Surgery, 1873; aged 92; former member of the Ohio State Medical Association, and past president of the Pickaway County Medical Society; died May 22. Dr. May had practiced in New Holland for 57 years. He was a member of the Masonic Lodge for over 60 years, and served for many years on the New Holland village board of education. Surviving him are his widow, four sons and four daughters.

Elon Howard Nelson, M.D., Mt. Healthy; Miami Medical College, Cincinnati, 1903; aged 59; died May 13 of heart disease. Dr. Nelson had practiced for 30 years at Mt. Healthy. He was a member of the Odd Fellow and Masonic lodges, and the Mount Healthy Welfare Association. His widow, one brother and four sisters survive him.

Harry E. Palmer, M.D., Dayton; New York Homeopathic Medical College and Flower Hospital, New York, 1885; aged 76; died May 20, of cerebral hemorrhage. His widow and one brother survive him.

Silas Warren Saxton, M.D., Steubenville; Jefferson Medical College of Philadelphia, 1903; aged 56; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 16 at Mercy Hospital, Pittsburgh, of nephritis. Dr. Saxton served his internship at West Penn Hospital, Pittsburgh. He practiced medicine at Burgettstown, Pennsylvania, for thirteen years before locating in Steubenville in 1917. Dr. Saxton was a veteran of the World War; a member of the American Legion, and the United Presbyterian Church. He is survived by his widow and one brother.

Augustus Charles Schwartz, M.D., Toledo;

Howard University School of Medicine, Washington, D. C., 1890; aged 75; former member of the Ohio State Medical Association; died June 8. Dr. Schwartz before his retirement several years ago, practiced at Miller City, Putnam County, and at Tiffin, as city health officer and Seneca County physician. Surviving him are two sons and one daughter.

John C. Snyder, M.D., Bowling Green; Rush Medical College, Chicago, 1891; aged 81; former member of the Ohio State Medical Association; died May 11 at the home of his daughter, Mrs. Blanche Schefler, of Newark, Ohio. Dr. Snyder served on the staff of Presbyterian Hospital, Chicago, for two years, and in 1893 located in Bowling Green, Ohio, where he practiced until 1931. Besides his daughter, he is survived by one son.

Raymond H. Spence, M.D., Painesville; Miami Medical College, Cincinnati, 1901; aged 56; former member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 28 of coronary thrombosis. Dr. Spence moved to Painesville from Wyoming, Iowa, in 1918. He was a member of the Masonic Lodge. Surviving are his widow, one son, one daughter, two sisters and one brother.

Herman Campbell Stevens, M.D., Elyria; Rush Medical College, Chicago, 1913; aged 56; member of the Ohio State Medical Association, and Fellow of the American Medical Association; past president of the Lorain County Medical Society; died May 27 at Elyria Memorial Hospital of pneumonia. Dr. Stevens had practiced in Elyria since 1920, and was a member and former president of the staff of Elyria Memorial Hospital. Much of his time in recent years was spent in his laboratory at Oberlin, where he carried on private medical research. He was physician for the American Red Cross in Albania after the World War. He was neurologist at St. Luke's Hospital, Cleveland, from 1929 until his death and was research fellow in experimental medicine at Western Reserve University since 1928. Surviving him are three daughters, one sister and two brothers.

Charles Alvin Thompson, M.D., Raymond; Starling Medical College, Columbus, 1887; aged 72; member of the Ohio State Medical Association; died June 6 of cerebral hemorrhage. Dr. Thompson had practiced in Raymond and Union County since his graduation. He was a member of the Presbyterian Church and a member of the Masonic Lodge. He is survived by one brother.

Samuel St. John Wright, M.D., Akron; Western Reserve University, School of Medicine, 1876; aged 81; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 29. Dr. Wright was the dean of the medical profession in Summit County. He had been a member since 1876 of the Summit County Medical Society and served as president in 1905. He was roentgenologist emeritus of Children's Hospital.

Harve George Young, M.D., Toledo; University of Michigan Homeopathic Medical School, Ann Arbor, Michigan, 1893; aged 63; died June 2, from self-inflicted gunshot wound. Dr. Young practiced at Pioneer and Bryan for several years before locating in Toledo ten years ago. He had been in ill health for several years. Surviving him are his widow, one sister and one brother.

KNOWN IN OHIO

James Hodgen Burkhead, M.D., Middleboro, Massachusetts; College of Physicians and Surgeons, Baltimore, Maryland, 1907; aged 53; died May 13. Dr. Burkhead was a native of Monroe County and in 1906 was associated in practice with Dr. F. C. Huth in Woodsfield. He practiced in Middleboro from 1908 until his retirement five years ago. He was a member of the Congregational Church, and the Masonic and Knights of Pythias lodges. Besides his widow, he is survived by his mother, one sister, and three half-sisters.

Walter S. Johnston, M.D., Pueblo, Colorado; Medical College of Ohio, Cincinnati, 1904; aged 62; Fellow of the American Medical Association; died May 15. He had practiced in Pueblo for 29 years. Surviving him are his widow, one daughter, one son; three brothers and two sisters.

Frank P. Klahr, M.D., Algona, Iowa; Eclectic Medical College, Cincinnati, 1875; aged 85; died April 24. Dr. Klahr was a native of Bloomville, Ohio, where he practiced for a few years following his graduation, and again after several years spent in Wisconsin. He retired from active practice in 1910 and moved to Washington, and later to Algona, Iowa. Dr. Klahr was a member of the Congregational Church, and was a Mason. He is survived by his widow, two daughters and one brother.

Edward Oscar Leberman, M.D., Upper Darby, Pennsylvania; Starling Medical College, Columbus, 1890; aged 70; died May 20 at Cleveland Clinic Hospital. Dr. Leberman formerly practiced in Akron, and at one time was coroner of Summit County. Two daughters survive him.

— OSMJ —

Optometry is a profession and therefore cannot be practiced by a corporation in the State of Ohio, the Ohio Supreme Court ruled in effect recently when it refused to issue a writ of mandamus to compel Secretary of State George S. Myers to issue incorporation papers to Kenneth B. Harris seeking to incorporate the Columbus Optical Company.

FREE CLINICS, SCHOOL HEALTH PROGRAMS AND MEDICAL SOCIALIZING FACTORS

Writing in the April, 1934, issue of *The American Mercury* under the title, "The Plight of the Doctor", George W. Aspinwall presented an interesting and critical analysis of some of the factors that have been primary contributors to the acute economic situation now confronting the medical profession in general and some of the events and developments that have placed "the socialization of the practice of medicine well within the realm of probability".

Mr. Aspinwall, while he does not say it in so many words, intimates rather strongly that militant, organized action by the medical profession in an effort to eliminate the evils cited by him and readjust certain parts of the present system of caring for the sick will be necessary to preserve the independence and economic security of the profession and prevent further, possibly complete, socialization of medical practice.

Overproduction of physicians shown by contrasting the increase in the number of physicians and the increase in the nation's population during the same period is cited by Mr. Aspinwall as one of the reasons why the average physician is "losing paying patients more rapidly than the statistically-inclined can compute".

The "ever-growing tendency to remove health work from the private doctor to centralized bureaus" and the competition afforded by limited and cult practitioners are listed as two other factors that have played no small part in the steady "shrinkage in the family doctor's pocketbook" and in the number of "paying patients" of the average physician.

However, Mr. Aspinwall is of the opinion that these items, important as they actually are, are not necessarily the chief causes for the doctor's "plight".

"For instance," he stated, "the number of persons attending so-called free clinics has increased 300 per cent in the last ten years. While the family physician has been losing paying patients to all sorts of new health cults, the number of patients whom he is expected to treat free of charge have been mounting at an almost incredible rate. Here is the chief cause of the shrinkage in the family doctor's pocketbook.

"To procure medical attention without paying for it has become a national habit. The doctors say it has assumed the proportions of a national mania. A man, who would not dream of asking a grocer for a free loaf of bread or a clothier for a free hat, has no hesitancy in asking his family physician how and where to procure free medical attention. And where this citizen, having a good job and probably some money in the bank, would have great difficulty in procuring free groceries or headgear, he has no difficulty in procuring free medical attention in clinics. Upon his first application for free food or clothes he would be questioned, investigated and refused by the charitable agency to which he applies. But he may walk into a free clinic and be given medical service with virtually no questions asked and at only a pittance of a charge.

"The trend of the people toward free medical agencies has spread even to the public schools. From kindergarten to high school, pupils are instructed concerning all sorts of free agencies for examinations and treatments of different kinds. Pupils leave school with the idea that the maintenance of health and the correction of disease are matters which need involve no expense."

Mr. Aspinwall expressed the opinion that "the foundation of the trouble which today has become the family doctor's greatest problem" was the organization of the first free clinics.

"Hospitals were built around these free clinics and found support from public contributions," he declared. "Staffs were employed at salaries, the doctors continued treating the poor free of charge, and the custom of giving free medical service developed into an organized business.

"At first, the free clinic was what the name implies. No charge of any kind was made to patients. But latter small fees were accepted and finally fees of ten, twenty-five and fifty cents were imposed. Even the poor could afford that, reasoned the heads of hospitals. There were electric bills to be paid, nurses' wages to be met, and other expenses, except for the doctors' services. It is now customary even in hospitals maintained by public and private contributions to make small charges for medical service and drugs in so-called free clinics. But it never has become customary for the doctor to be paid for his work in these clinics. As a matter of fact, many doctors have been dismissed from hospital staffs for violating the rule which forbids a doctor from inviting a clinic patient to become his private patient.

"And once a free patient always a free patient. Doctors have observed that they rarely ever are visited again by a patient after that patient has acquired the free clinic habit. The patient reasons that he was a fool indeed, ever to have paid doctors' bills.

"There are 500,000 persons in this country being treated in free clinics each day. It may be assumed that the attention given the average patient is worth a minimum of $2.00, as this attention is exactly what the patient has been getting from his family doctor. As in all free clinics the doctors donate their services, it may truthfully be said that the doctors are donating $1,000,000 daily to the sick poor and those who pretend poverty to procure free medical service."

Mr. Aspinwall believes that the pay clinic "is another irritating thorn in the doctor's side". This class of clinics, "some connected with medical colleges, others surreptitiously maintained by hospitals", was established, he pointed out, to give medical care to the middle-class, it being

contended that the middle-classers could not procure proper medical attention at a price they could afford to pay.

"With the establishment of pay clinics another large group of patients left the family physician," he said, "for the pay clinics offered a competition difficult for the private doctor to meet. The word clinic, long associated in the public mind with free medical care, indicated to Mr. and Mrs. Citizen cheaper medical service than the family doctor had to offer. Also, these large halls of healing with splendid and complete equipment seem more attractive than the office of the family doctor.

"Opinions concerning pay clinics vary widely and today these clinics are the subject of one of the most bitter discussions in the history of the medical profession. Pay clinics are frankly money-making ventures, but as in the case of the free clinics, the doctors who serve in the pay clinics receive nothing for their work.

"The doctors contend that they have as efficient and economical service as the pay clinics offer. The entrance fee to a pay clinic is small but the patient finds that he must pay many other fees. There are charges when a patient is referred from one department to another, and there are charges for consultations and for laboratory work. Opponents of pay clinics assert that these clinics have shown themselves not superior but greatly inferior to the private doctor in serving the middle-class. * * *

"But both proponents and opponents admit that the pay clinics are steadily making inroads upon the practice of the private doctor whose financial condition can withstand no additional drain. The fight revolving around the pay clinics within the medical fraternity may become the foundation upon which a new medical structure will be built."

Uncle Sam lopped off a considerable portion of the doctor's income by erecting many enormous hospitals and establishing a gigantic medical service for the care of World War veterans free of charge and regardless of the cause or origin of the veteran's disability, Mr. Aspinwall pointed out. An additional decrease in the family doctor's business was brought about, he said, through the enactment of that type of workmen's compensation legislation which prohibits the free choice of physician by disabled claimants and permits each insurance carrier to designate one or a small group of physicians to handle all cases in which that particular insurance company is interested.

In conclusion, Mr. Aspinwall reviewed efforts made by the medical profession of New York State to curb the free clinic and pay clinic evils, prohibit competition from hospitals, preserve the free choice of physicians in the workmen's compensation system, etc.

To sum up and appealing to the profession for a concerted and vigorous effort on its part to correct and have corrected the situation in which it now finds itself, Mr. Aspinwall declared:

"It may seem that family doctors have been sitting supinely in their offices while important groups of their patients were being taken away. It is true that as a general rule they have not been so active as they might have been in protecting themselves. But private physicians, working both as individuals and through their various organizations, have made efforts to avoid being deprived of their income. So far their efforts have resulted in failure or only partial success.

"The family doctor never has been politically important. He has been too busy with his practice to find time for meddling in politics. But it seems that now, when he cannot earn enough money to support his family, he may meddle politically a bit.

"The family doctors of not only New York State but throughout the country are sufficiently numerous with their families and friends to wield a powerful political influence if they should band together under proper leadership to battle with the ballot for self-preservation."

— OSMJ —

Dermatitis Still Leading Factor in Compensable Occupational Diseases

Dermatitis continues as the leading factor in compensable occupational diseases in Ohio, with more than 58 per cent of the year's total falling within this category. The Bureau of Occupational Diseases of the State Department of Health has lately filed its annual report under Sec. 1243-1 G. C., showing a total of 1258 cases in 1933, compared with 1159 in 1932. These gross figures do not vary much from those reported in each of the preceding five years. In the non-compensable occupational diseases it is noteworthy that dust inhalation, principally silicosis, occupies about the same relative position to the entire field as dermatitis does to the compensable list. Increase in silicosis and copper-sodium cyanide poisoning indicates that these are leaders in the list which should be added to occupational diseases compensable under the law.

Of the 21 afflictions which are *compensable* under the Ohio law (Sect. 1465-68a), only 16 registered reports. Of these, dermatitis (variously specified) comprised 726, tenosynovitis 191, lead poisoning (and lead absorption) 134, chrome ulceration (nasal or skin) 20, prepatellar bursitis 19, brass or zinc poisoning 12, volatile petroleum products 9, potassium cyanide poisoning 5, benzol poisoning 3, compressed air illness 3, sulphur dioxide poisoning 2, and one each of the following: phosphorus, arsenic, carbon bisulphide, tar epithelioma and carbon dioxide, total 1129. In addition, 104 *non-compensable* occupational diseases were reported where the causative agent was specified, and 25 where only the nature of the affliction (as bronchitis, tuberculosis, etc.) was stated. Chief among the non-compensable diseases were those due to dust inhalation, total 47, principally silicosis. Copper-sodium cyanide also comprised 23 in this group.

Of the 1258 occupational diseases, 300 occurred through inhaling the substance, 732 by

way of the skin, 202 through strain, and 23 through friction.

Acute mishaps, even though due to poisons, sudden strains, etc., are not included in the above figures.

Lead poisoning occurred in various industries: Storage batteries, 51; paints, dry colors, and painting, 15; lead manufacturer or recovery, 14; automobiles, 8; printing and publishing, 8; caskets and vaults, 5; pottery, 4; sanitary ware, 4; rubber, 3; and the balance scattered. Approximately half of the lead poisoning cases were considered to be no more than lead absorption. Only one female worker (tile scraper) was involved.

Of the 732 total cases of *dermatitis*, 142 occurred among females. The leading causes of dermatitis were exposures to alkalies and cleansers 47, bakelite 22, gasoline 39, chromium compounds, 24, dyes and dyed goods 42, lime and cement 33, oils and cutting compounds 109, paints, enamels, etc. 15, fungi, etc. 21, plants, woods, etc. 28, plating solution 18, rubber 39, and textiles (probably dyed) 24. Females led in leather, textiles and fungi, etc., and practically equalled males in solvent cements and dyed goods.

From the date of the receipt of the first reports, May, 1913, a total of 15,887 occupational diseases has been reported to and including December 31, 1933. During the first eight years, before occupational diseases became compensable, only 2,575 or an average of 322 cases per year were reported. Since compensation began (Aug. 4, 1921), 13,312 have been reported, or an average of 1065 per year.—*Ohio Health News.*

—OSMJ—

Crile Fellowships Awarded

Registrar John F. Berry, School of Medicine, Western Reserve University, has announced awards of fellowships and scholarships offered by the Crile Foundation to the following students: Franklin Alois Benes, Shaker Heights, in biochemistry; Jacob Michael Werle, Cleveland, in histology; Allan Bookatz, Cleveland, in bacteriology; John Beverly Bull, Cleveland, in physiology; Nathan Pinchas Frolkis, Cleveland, in anatomy; James Linek, Cleveland, in biochemistry; Harold Victor Morley, Ashtabula, in anatomy. Donald Curtiss Snyder, Medina, in physiology; Eugene Joseph Stanton, Oil City, Penna., in pharmacology; Paul Werle, Cleveland, in anatomy; Paul Mitchell Glenn, Cleveland, in pathology; Miss Mary Ruth Oldt, Canton, China, in pathology; Kenton Robinson Phelps, Kent, pediatrics; and William Benjamin Seymour, Jackson, Michigan, in medicine.

—OSMJ—

Lima—Dr. Arthur Hertzler, Halsted, Kansas, will be the guest speaker at the annual postgraduate assembly of the Academy of Medicine of Lima and Allen County next October.

New Ohio Society Organized for Promotion of Obstetrical Service

Having as its purpose "to develop better methods for hospitalization and care of the obstetrical patient and the newborn child; to study all the conditions which affect the welfare of patients who enter hospitals for obstetrics care and to introduce and standardize methods for the improvement of the care of such patients", an organization known as the Hospital Obstetric Society of Ohio has been organized by obstetricians representing most of the larger hospitals in Ohio.

Officers of the society are: President, Dr. A. J. Skeel, Cleveland; vice president, Dr. Walter W. Brand, Toledo; secretary, Dr. Scott C. Runnels, Cleveland; and chairman of publication committee, Dr. Andrews Rogers, Columbus.

At a meeting of the society in Columbus on May 5, Dr. Skeel outlined the plan of organization and emphasized the purposes of the organization.

"We propose," he declared, "to carry out on a magnified scale the methods and purposes of the staff conference, viz: review of cases, formation of statistics, study of results, and the discussion of methods to improve those results, whether those methods are clinical or organizational in their nature. Our work is distinctively practical, not theoretical. It will deal with doctors and their effectiveness in applying scientific knowledge, with men and their methods, rather than with theories of disease."

Dr. Skeel proposed the following program of activity for the society which subsequently was officially approved and adopted by the society as a medium for accomplishing the results that it hopes to obtain:

1. The adoption of a continuous audit system of hospital obstetrics, mortalities and morbidities. This system is to be conducted by obstetricians, as the only competent judges of case reports. The methods already in use by The Cleveland Hospital Obstetric Society (with modifications as are needed from time to time) to be used by the state society.

2. The development of a code of rules and regulations to govern hospital obstetrics. This code should regulate: (a) conditions of housing and equipment; (b) administrative policies, whenever such policies are directly related with the patient's welfare.

3. A uniform system of staff organization and control. By staff is meant not only the so-called regular staff, but the courtesy or affiliate staff as well. The courtesy or affiliate staff should be a compact organized body. The term should not be loosely applied to all who wish to care for patients in the hospital. All obstetric cases delivered in the hospital should be subject to the supervision and control of the obstetrics chief,

either directly or through his selected representatives.

4. The enactment of legislation which will compel conformity with the principles of such a code, by institutions or individuals who from selfish motives or indifference are unwilling to comply.

5. Systematic development of hospital facilities for maternity cases throughout the state, with distribution designed to give both metropolitan and rural population suitable service.

6. A consistent program of teaching women the importance of prenatal care.

7. As nearly complete hospitalization of maternity cases as the facilities and conditions of individual communities will permit.

In his comments on the above program, Dr. Skeel discussed at some length the matter of improving staff organization which he said is the most difficult of attainment and the most vital to the success of the entire program.

"Our society consists at present largely of Group 1 hospitals (those with 24 or more bassinets)," he declared. "We should begin with this group. Our work in Cleveland, and with the preliminary organization of this society, revealed a most distressing lack of correct staff organization, even in hospitals with large maternity divisions. Some hospitals with 24 or more beds have not so much as recognized the obstetrics department by the appointment of an official head. Others have a sort of hybrid arrangement by which the heads are rotated quarterly or annually. Those in authority have refused to accept the responsibility of selecting an accouchour and holding him responsible for the welfare of the service. It seems obvious that the first duty of a hospital doing an appreciable volume of maternity work is to select a competent obstetrician to supervise and direct this important department. Failure to do this is an admission that professional jealousy controls the situation or that the hospital has no one who is competent to occupy such a position.

"The hospital must select its own staff with extreme care, choosing men of unusual skill and with the highest ideals; place on its courtesy staff only such men as will use its facilities with an eye single to the patient's welfare; establish such standards, rules and limitation on practice within its walls as are necessary to give the patient the highest degree of safety.

"The courtesy staff of the hospital should be more formally organized than is at present the case. Men desiring to use the hospital for their patients should have presented to them a copy of the rules regulating the courtesy staff and should formally accept the responsibility of abiding by those rules. In small institutions a highly organized staff may be impossible. However, the smallest hospital accepting obstetric patients can appoint a consulting obstetrician who can advise on policies, technique and housing arrangements. Such flagrant violation of the essential principles of safe obstetric service, as the combined operating room and delivery suite, miscellaneous distribution of nursing service among surgical and maternity cases would thus be obviated."

— OSMJ —

New Books Received

Diseases Peculiar to Civilized Man: Clinical Management and Surgical Treatment, by George Crile, M.D., Cleveland; a presentation of the theme that certain diseases such as neurocirculatory asthenia, hyperthyroidism, peptic ulcer, diabetes and epilepsy are related diseases and result from the tension of highly civilized life which causes a disturbance of the glandular and autonomic nervous system, particularly the adrenal glands, including a description of the author's operation for removal of part of the adrenal glands or destroying the sympathetic nerves about them. MacMillan Company, New York, publishers; price, $5.00.

Industrial Toxicology, by Alice Hamilton, M.D., a treatise written especially to aid the general practitioner in the diagnosis and medical supervision of industrial poisonings; Harper and Brothers, 49 E. 33rd Street, New York City, publishers; price, $3.00.

The Medicolegal Necropsy, edited by T. B. Magath, M.D., Rochester, Minnesota, for and published under the auspices of The American Society of Clinical Pathologists; a monograph dealing with the determination of the cause of death in alleged criminal cases, as well as in some others which are subject to review in courts of law, based on the subjects presented at a symposium held at the 12th annual convention of the society at Milwaukee, June 9, 1933; Williams and Wilkins Company, Baltimore, publishers; price, $2.50.

Genealogy of Sex, by Curt Thesing, M.D., German biologist; a treatise on sex in its myriad forms, from the one-cell animal to the human being, translated from the German by Eden and Cedar Paul and with an introduction to the American edition by Smith Ely Jelliffe, M.D., consulting neurologist, Manhattan State Hospital. Emerson Books, Inc., 333 Sixth Avenue, New York City, publishers; price $5.00.

I Know Just the Thing for That! by J. F. Montague, M.D., Medical Director, New York Intestinal Sanitarium. Dedicated to patients without doctors, and doctors without patience. The John Day Company, New York City, publishers, price $2.00.

NEWS NOTES of OHIO

Columbus—Dr. Frank W. Harrah discussed papers on bilateral renal carcinomata, tissue changes in mixed tumors of the kidney after Roentgen therapy, and primary tumors of the ureter at the recent annual meeting of the American Urological Association at Atlantic City.

Marietta—Dr. J. F. Weber addressed the Civitan Club on "The Physician's Responsibility in Public Health Administration".

Canton—Dr. Harold C. Schmuck has returned after completing postgraduate work in surgery at the New York Post Graduate Medical School and Hospital, Columbia University.

Warren—Dr. H. J. Meister has been commissioned a major in the Medical Officers Reserve Corps.

Cleveland—Dr. J. D. Varney, Dayton, was installed as president and the following officers elected at the closing session of the annual meeting of the Ohio State Homeopathic Medical Society held here: president-elect, Dr. Scott C. Runnels, Cleveland; vice president, Dr. L. A. Jackson, Columbus; treasurer, Dr. George H. Irvin, Orrville; secretary, Dr. E. O. Marshall, Cleveland; editor of bulletin, Dr. J. R. Horner, Cleveland.

Springfield—Miss Elsie Druggan, Athens, was elected president of the Ohio State Nurses' Association at the annual meeting of the organization held here. Other officers are: vice presidents, Miss Catherine Buckley, Cincinnati, and Miss Celia Cranz, Akron; secretary, Miss Helen Haughton, Columbus; treasurer, Miss Ruth Klotz, Columbus, and trustees, Miss Marguerite E. Fagen, Cincinnati, and Miss Huldah Wyland, Toledo.

Canton—Dr. R. H. Firth has resigned after nine years' service as school physician.

Wooster—Dr. F. R. Dew, former health commissioner of Belmont County, is temporary health commissioner of Wooster and Wayne County, serving for Dr. W. G. Rhoten, who is on a leave of absence.

Canton—The public has many misconceptions about high blood pressure Dr. O. G. Wilson told the Canton Exchange Club in a recent luncheon address.

Youngstown—A medical-dental credit bureau has been organized here and incorporated by members of the Mahoning County Medical Society and the Corydon Palmer Dental Society, with a present membership of 96 physicians and dentists.

Columbus—Memorial services were held recently on the campus at Ohio State University in honor of three members of the medical faculty who died recently, namely: Dr. Ernest Scott, Dr. F. L. Landacre and Dr. Albert Bleile.

—*West Union*—Announcement has been made of the marriage of Miss Ruth Davidson and Dr. M. L. Purdin.

Delaware—Dr. A. R. Callander has returned from two months' study at Vienna.

Gallipolis—Dr. Charles E. Holzer recently underwent an operation for appendicitis.

Cincinnati—Dr. Joseph T. Clear has been promoted to the post of senior attending gynecologist at St. Mary's Hospital, Ciucinnati.

Ashtabula—Dr. J. H. Park and Dr. A. M. Mills were recent speakers before the local Kiwanis Club.

Killbuck—Dr. N. P. Stauffer, formerly of Toledo, has opened offices here.

Delphos—Dr. G. P. Bohlender, for the past two years on the intern and resident staffs of the Miami Valley Hospital, Dayton, has opened offices here.

New London—Dr. L. D. McMillan, formerly of Clear Lake, Michigan, has located here.

Zanesville—Dr. A. C. Ormond, formerly of Byesville, has opened offices here.

Toledo—Dr. E. E. Lyon has been appointed physician at the Lucas County Jail.

Martins Ferry—Dr. F. S. Wright has resigned as a member of the city board of health.

Deshler—Dr. A. P. Conti is taking post-graduate work at Bellevue Hospital, New York City.

Xenia—Dr. L. G. Bowers, Dayton, addressed the Xenia Kiwanis Club on "Progress of Medicine".

Dayton—Dr. M. B. Menke is taking post-graduate work at Harvard University.

Coshocton—Dr. Roy D. Hildebrand is taking post-graduate work in orthopedic surgery at Harvard University.

Akron—Dr. A. J. Devany has been appointed physician at the Summit County jail, succeeding the late Dr. George M. Logan.

HOSPITAL NOTES

—Appointment of the following internes at Jewish Hospital, Cincinnati, has been announced: Carl Roush, Louis B. Sternberg, Ralph Cunningham, Nathan Abrams, Karl Kraus, William Vinnedge, Bernard Schneider, and Milton Gottlieb.

—The following resident physicians and internes have been appointed at Lucas County Hospital, Toledo: Residents, G. R. Hazel, University of Indiana; C. A. Dryer, Temple University; R. P. Joyce, University of Pennsylvania, and H. L. Sedam, University of Indiana; internes, Samuel L. Adair, Jr., University of Louisville; Donald G. Carlson, Loyola University; Harry J. Grossman, Northwestern University; Richard Hotz, University of Cincinnati; Joy D. Huss, St. Louis Medical School; Houston W. Shaw, University of Cincinnati; Francis M. Wadsworth, Ohio State University; Bryce P. Weldy, University of Indiana; Gerald G. Woods, University of Michigan, and LaVerne C. Ziegler, Ohio State University.

—A fund of $100,000 to be used in establishing a home for incurables in connection with the Huron Road Hospital, Cleveland, was set up under the will of the late Mrs. Mary E. Wickham, New York City, formerly of Cleveland.

—The new tuberculosis ward of Lake County Memorial Hospital has been opened.

—The Chillicothe Hospital was left $5,000 for its building or endowment fund by the late Arthur B. Howson.

—The following advisory staff has been elected at Ft. Hamilton Hospital, Hamilton: Drs. Merle Flenner, Dan Skinner, F. P. Zerfass, C. L. Weston and Mark Millikin.

—Dr. George R. Taylor has been elected chief of staff of Citizens' Hospital, Barberton. Dr. Gerald W. Hamilton was elected secretary.

—At the annual meeting of the staff of Good Samaritan Hospital, Cincinnati, Dr. Ralph Carothers was elected president; Dr. Howard D. McIntyre, vice president; Dr. John J. Maloney, secretary, and Dr. George Topmoeller, treasurer. The following appointments were voted: Fellowship in surgery, Dr. L. C. Jack; resident in medicine, Dr. L. P. Stickley; resident in pediatrics, Dr. E. J. Bender; interns, Michael J. Barrett, Herbert J. Brinker, August F. Fath, Robert E. Khuon, J. Philip Owens, G. Howard Wood, Richard B. Homan and Charles Sonneman, University of Cincinnati; Herbert N. Cavanaugh, St. Louis University; Harry Daugherty, University of Louisville; Bruce R. Powers, Jefferson Medical College, and John S. Squires, Ohio State.

—At the annual meeting of Mercy Hospital, Columbus, Dr. Joseph Price was re-elected treasurer and chief of the staff. Among members of the board of trustees are Dr. Price, Dr. J. E. Berry, and Dr. I. B. Harris.

—Dr. Fred Fletcher has been reappointed director of surgery, Dr. W. F. Milhon, director of medicine, and Dr. W. G. Inglis, director of obstetrics, at White Cross Hospital, Columbus. These three and Drs. R. W. Kissane, Russell Means and F. W. Harrah compose the medical council.

—At a meeting of the staff of St. Elizabeth Hospital, Dayton, Dr. Curtiss Ginn was re-elected chief of staff and Dr. Richard Hochwalt was re-elected secretary.

—The staff at Miami Valley Hospital, Dayton, has elected Dr. Warren C. Breidenbach chief of staff; Dr. T. H. Dickinson, vice chief, and Dr. R. D. Hostetter, secretary.

—The county commissioners of Coshocton County have under lease a site on which it is planned to build a county hospital providing a loan from the Federal government can be obtained.

—Dr. J. M. Firmin has been re-elected chief of staff of the Home and Hospital, Findlay. Dr. E. J. Thomas was elected assistant chief of staff.

—Lake County Memorial Hospital staff has elected Dr. George F. Barnett chairman; Dr. C. H. Browning, vice chairman; Dr. James G. Powell, secretary, and Drs. J. J. Winans, Frederick J. Dineen and Mabel L. Pearce, members of the executive committee.

—Dr. Harry Harris has been elected president of the staff at the Martins Ferry Hospital. Dr. Edward Arbaugh Jr., was elected secretary.

—Dr. Harold T. Copeland has been reappointed chief of staff of the Bedford Hospital.

—Dr. Carl A. Hyer has been named chairman of the staff at Mt. Carmel Hospital, Columbus. Dr. Judson D. Wilson was elected secretary and the following advisory board was chosen: Drs. J. J. Coons, president; H. O. Bratton, secretary; E. J. Emerick, E. Harlan Wilson, Charles E. Turner, Hugh Beatty, and Leslie M. Lisle.

—Departmental directors of Mercy Hospital, Toledo, have been appointed as follows for the ensuing year: Medicine, Dr. Nelson Morris; surgery, Dr. B. W. Patrick; urology, Dr. Leo P. Dolan; gynecology, Dr. R. F. Heatley; obstetrics, Dr. H. W. Nelles; oto-laryngology, Dr. E. A. Orwig, and pediatrics, Dr. V. F. Dunham.

PUBLIC HEALTH NOTES

—Scarlet fever still heads the list of communicable diseases during 1934, according to the *Ohio Health News*, state department of health publication. In 1933, 25,292 cases were reported to the department. Commenting on this disease, *The News* said:

"While there has been a very decided decrease in the incidence of most of the communicable diseases in Ohio, scarlet fever most assuredly is not one of them. There has been no year since 1920 in which the reported cases have numbered less than 10,000, and no one can estimate the number unknown to physician and health official.

"And it is to these mild, unreported cases, to cases unrecognized as scarlet fever, or perhaps suspected as such and concealed by thoughtless or unscrupulous parents, that there can be attributed the continued wide prevalence of the disease and the almost impossible task the health official has in attempting to check a local outbreak.

"When case after case occurs in a community despite the earnest, conscientious efforts of local health officials, it may be regarded as almost conclusive evidence that somewhere in that community there are citizens who are a menace to public welfare. Concealment of cases *may* be due to ignorance, but usually it is because parents hope to escape quarantine; so then, it can only be classed as being due to a selfish carelessness of other people's safety. As everyone is aware that the lives most greatly endangered by scarlet fever are those of tender years—infants and little children—these people should be ferreted out and brought to public attention as bad citizens, and undesirable and dangerous neighbors.

"Parents should be taught that any case of sore throat in a child is suspicious when scarlet fever is in the neighborhood, and that a child having this symptom should be kept at home until a physician has seen him; that children should be kept away from the home in which there is a known or suspected case or in which there is a case of sore throat, and that infants and young children should not be taken to any public gathering when scarlet fever is prevalent.

"Scarlet fever is the disease 'treacherous beyond all diseases' because its onset is so abruptly in full force with little previous warning, and because the 'light' case apparently does not demand serious attention. Thus neglected, it often drifts into some complication that either kills the victim or leaves him with some damaged organ that handicaps him through life."

—Dr. William H. Peters, health commissioner of Cincinnati since 1918 and a member of the Cincinnati Health Department since 1912, has been retired at his own request because of poor health. Dr. Peters has been suffering from heart trouble for the past six months. Dr. Owen C. Fisk has been appointed acting health commissioner. Under Dr. Peters' regime, Cincinnati became a leader in public health activities throughout the nation and is recognized as one of the most healthful cities in the country.

—In a recent issue of the *Ohio Health News*, the following tabulation of human diseases carried by animals, fowls, insects, etc., was published:

1. *By the dog:*—Rabies; foot and mouth disease; helminthiasis—flukes, tapeworms (especially taenia echinococcus); infantile splenomegaly (from dogs through fleas); trypanosomiasis (T. gambinese); mange; fleas and ticks; ringworms; favus.

2. *By the cow:*—Tuberculosis; actinomycosis; anthrax; cowpox; undulant fever; foot and mouth disease; septic sore throat; rabies; pus infections; tenia saginata; milk sickness; paratyphoid fever.

3. *By the horse:*—Glanders; rabies; tetanus; sporotrichosis; anaphylaxis—serum disease, odor of horses.

4. *By swine:*—Trichiniasis; tuberculosis; anthrax; cestodes (especially T. solium); trematodes.

5. *By sheep:*—Anthrox; tuberculosis.

6. *By goats:*—Malta fever (undulant fever); tuberculosis.

7. *By wild rabbits:*—Tularemia.

8. *By the cat:*—Rabies; cestodes; trematodes; favus; ringworm.

9. *By rats:*—Rat bite fever; bubonic plague (through fleas); trichiniasis (through hog to man).

10. *By ground squirrels:*—Bubonic plague; tularemia.

11. *By birds:*—Psittacosis (from parrot).

12. *By fish:*—Tapeworms.

13. *Arthropoda, chiefly insects:*—Mosquitoes: Yellow fever, malaria fever, dengue fever, filariasis. Fleas: Bubonic plague, infantile splenomegaly. Ticks and mites: Rocky Mountain fever, relapsing fever (African), tick fever of Miana, Japanese flood fever. Lice: Typhus fever, relapsing fever (spirochoeta obermeieri). Bed bugs: Kala azar. Flies: Sandfly fever, sleeping sickness (African tse-tse fly), typhoid fever and other infections carried mechanically. Crustaceans (water flea): Guinea worm infection (draucunculosis). Oysters, clams, etc.: Typhoid fever. Snails: Trematode infection.

Advice Concerning Expert Testimony As Given by An Experienced Jurist

Sporadic outbursts of caustic criticism concerning the present procedure in obtaining expert medical testimony and at the apparent inconsistencies which have arisen to create suspicion and distrust on the part of a considerable number of persons relative to the value of physicians' opinions in litigation emphasize that this troublesome question remains unsolved.

Undoubtedly, at some future time constructive steps will be taken by the courts or through legislation to remedy this unfortunate situation which is repugnant to the medical profession and make many physicians the victims of unjust and uncalled for criticism.

However, until that time comes, the responsibility for keeping expert medical testimony on the highest possible plane rests for the most part with the physician summoned to present his expert opinion on matters pending before the courts.

Some timely advice to physicians in connection with the questions of what is expected of him and how he should conduct himself when called to the witness stand was given to members of the Cincinnati profession not long ago by Judge Benton S. Oppenheimer in an address before the Cincinnati Academy of Medicine.

Commenting on the apparent reasons for the unfavorable light which has been cast about the physician on the witness stand, Judge Oppenheimer said:

"Unfortunately, there is no type of witness who is so frequently looked upon with suspicion as the medical expert. It may be that this attitude of the public is wholly unwarranted, but of its existence there can be no doubt.

"Why then this distrust (if it indeed exists) of the physician in court? In no other relation—not even that of attorney and client—does such complete confidence exist as that between physician and patient. When the doctor walks into the court room, he must of necessity have in mind the fact that he merits and enjoys the respect of all those who know him. Why then does he instinctively feel that the 'twelve average men and women' in the jury box look upon him with suspicion and distrust, and are prepared to take his assertions, however solemn, *cum grano salis?*

"The answer, I think, may be found in the obvious, and perhaps natural, partisanship of the profession. Its members feel somehow that they are necessarily upon one side or the other of the case on trial. They are interested in the outcome of the controversy—they wish to find that their opinions are vindicated, or that their friends or patients succeed. They frequently manifest their bias and partisanship by their demeanor and manner of testifying, and thus render their opinions valueless to the jurors.

"Now it is by no means strange that the doctor should have certain prejudices or preferences. He may have either a friendly or financial interest in the outcome of a case; he may be justifiably proud of the results of his treatment; he may regard the claims which are asserted as groundless or exaggerated, or he may feel that justice can be done only by a verdict in favor of the party who has called him to the stand. His prejudices, in other words, may be wholly natural and ethically meritorious. But his value *as a witness* depends upon his ability to conceal this natural bias, and to create the impression of absolute and undeviating impartiality. The medical witness who plainly manifests his interest; whose demeanor discloses his partisanship; whose intonation bespeaks his partiality, is unquestionably injuring the cause which he seeks to aid. On the other hand, the calm, dignified witness who frankly and fairly answers all questions; whose manner shows that he is motivated by no purpose save a desire to speak the truth and to aid the jurors in arriving at a just conclusion, has an influence upon them which may be wholly disproportionate to his learning or ability. Let me epitomize it all by saying that the value of the physician's testimony is dependent far more upon its form than upon its content—more upon the manner in which his testimony is given than upon its scientific worth or exactitude. His education and training make it possible for him to be particularly impressive; but they may also become instrumentalities for rendering him ridiculous in the eyes of those who, by reason of their own limitations, may be unable to understand or appreciate him.

"It is essential, then, that he avoid studiously all appearance of parading his accomplishments or advertising his wares. There must be no display of learning or pride of achievement. Technical language must be scrupulously shunned or carefully explained in terms which may be intelligible to such persons as ordinarily compose our juries. Occasionally technical terms may be required, but explanations should be promptly made without even awaiting further question by counsel.

"Nor should the expert witness ever hesitate to admit that he does not know, or that he cannot be positive concerning his answer to specific questions. If it should ultimately appear (as it doubtless will) that he is in fact ignorant upon the subject, any ordinarily beneficial effect of his other testimony will be promptly destroyed.

"Much, of course, will depend upon the lawyer who calls the physician to the witness stand. He, too, must be possessed of at least a modicum of knowledge concerning anatomy, surgery and pathology—sufficient, in any event, to enable him to lead his medical witnesses along the proper path, as well as to outline to them in advance the subject concerning which they will be required to testify. In most cases it is well for the physician to require before trial some information con-

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cerning the subject matter which is to be discussed, and perhaps to familiarize himself (if he should not already be entirely familiar) with the literature so that he may meet the attempted cross-examination of some impertinent counsel who knows nothing about the subject, but has learned a few names or the titles of a few books, which he does not hesitate to use indiscriminately —and with which he may vastly impress an undiscriminating jury.

"The great bugaboo of the expert witness is ordinarily the hypothetical question, by which is meant one that assumes as true certain probative facts which have appeared in evidence and calls for the opinion of the witness thereon concerning some ultimate fact at issue. When the doctor is aware that such hypothetical question is to be flashed upon him, it is frequently wise to require that he be furnished with a copy thereof before he enters court, so that he may acquaint himself with all the elements thereof. He is at liberty to ask the counsel who propounds the question for information concerning any additional facts which may, in his opinion, affect the situation. In other words, he should in all cases thoroughly understand the question before he attempts to answer—and it is particularly wise to have in mind all the possible inferences which may properly be drawn from the answer, and to know to what it may ultimately lead. Some of these hypothetical questions 'are of great length and labyrinthian construction, the ambiguity of which is equaled only by the profound darkness shed by the answers thereto'. If the doctor wishes to make his testimony valuable, he must frequently insist upon simplification or amplification—and even then it is sometimes more impressive to say that he cannot answer than to permit the jurors to feel that his answer is not helpful to them. It may be profitably borne in mind that the court will always permit an answer to be explained, and will never force an answer to a question which is not understood. Candor and honesty are required as well of the professional witness as of the layman who undertakes to testify only to that which he has actually observed, and who is not permitted to express any opinions.

"It has frequently been suggested that professional witnesses should carefully avoid any attempt to appear to be humorous—that they leave all that to the court and the jury. This is not entirely true. Any witness who relieves the seriousness of the situation by homely illustration or kindly pleasantry—provided he does not appear to be attempting ridicule or to belittle a cause—will gain closer attention of the jury, and will have a persuasive influence over them which arises largely out of the fact that he appears to be human."

Naturally, Judge Oppenheimer's suggestions do not cover the case of the unscrupulous physician who does not hesitate to offer his scientific knowledge to the highest bidder. Such instances, although few, have played the biggest part in making expert medical testimony questionable. However, his advice should be of value to the inexperienced, but honest, physician who desires to do the right thing while on the witness stand but who lacks an understanding of jury psychology and of court procedure. As has previously been stated, the question can be partially solved by a bit more care and judgment on the part of the individual physician when he is called to assist in seeing that justice is served.

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Dr. Franklin Named to Medical Board

Dr. Lewis T. Franklin, Chillicothe, has been appointed a member of the State Medical Board by Governor George White for the term, ending March 18, 1940. Dr. Franklin succeeds Dr. J. Stewart Hagen, Cincinnati. Dr. Franklin is a graduate of the Eclectic Medical College, Cincinnati, of the Class of 1908.

— OSMJ —

Congress of Physical Therapy

The thirteenth annual scientific and clinical session of the American Congress of Physical Therapy will be held in Philadelphia at the Bellevue Stratford, September 10, 11, 12, 13, 1934. This year's session will be especially noteworthy because of the excellent program which has been arranged. Outstanding clinicians and teachers will present the results of the newer researches in the field emphasizing short wave therapy, hyperpyrexia, light therapy, remedial exercise, massage and other interesting subjects. On Wednesday evening, September 12th, a joint session will be held with the Philadelphia County Medical Society.

— OSMJ —

Announcement has been made that the Nineteenth Annual Clinical Session of the American College of Physicians will be held in Philadelphia, April 29 to May 3, 1935. The program will be arranged under the direction of Dr. J. C. Meakins, Montreal, Que., president of the organization. Local arrangements are in charge of Dr. Alfred Stengel, vice president in charge of medical affairs, University of Pennsylvania. General and business details will be handled by E. R. Loveland, executive secretary of the College of Physicians, 133 S. 36th Street, Philadelphia.

— OSMJ —

A 60-page summary of the report of a study of maternal mortality in 15 states by the United States Children's Bureau, in cooperation with the health departments of the states surveyed, has been prepared by the bureau. The summary presents and analyzes the pertinent data obtained from the study and may be obtained from the Superintendent of Documents, Washington, D.C. for 5 cents per copy. The full report, with tables and analyses, will be published at a later date, but because of the size of the volume, the edition will necessarily be a small one. The states surveyed were: Alabama, Kentucky, Maryland, Michigan, Minnesota, Nebraska, New Hampshire, North Dakota, Oregon, Rhode Island, Virginia, Washington and Wisconsin, California and Oklahoma.

— OSMJ —

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Medicinal Whisky Ruling Issued by Drug Administration

The Food and Drug Administration has issued a statement intended to clarify the specific requirements of the Federal Food and Drugs Act as they apply to medicinal whisky. The announcement supplements but does not in any way conflict with the labeling regulations covering beverage whisky recently issued by the Federal Alcohol Control Administration. It shows that whisky sold for drug purposes is subject to requirements which do not apply to an article intended exclusively for beverage use.

The Food and Drug Administration emphasizes that the requirements it enforces in regard to medicinal whisky are not administrative rulings, but are set forth in the Food and Drugs Act which requires that drugs listed in United States Pharmacopoeia shall conform to the definition in that authority. The definition for whisky in the U. S. Pharmacopoeia is more rigid than the definition of "straight whisky" which the FACA issued February 6, 1934, in that Pharmacopoeia whisky must be aged four years in charred wood containers, and its alcoholic content must be not less than 47 per cent and not more than 53 per cent by volume of absolute alcohol. Medicinal whisky which does not conform to the pharmacopoeial standard must be labeled to differentiate it clearly from the official product.

A drug sold within the jurisdiction of the Federal Food and Drugs Act as *"Whisky," "Spiritus Frumenti,"* or *"Sp. Frum."* must comply exactly with the definition of "whisky" in the U. S. Pharmacopoeia and otherwise satisfy the provisions of that authority for "Whisky." It must be labeled with a statement of the quantity of alcohol in terms of the percentage by volume of absolute alcohol.

A drug varying from the Pharmacopoeial specifications for "Whisky" in strength, quality or purity (but not in the identity of its constituents or of the materials from which it is made) may be sold as "whisky not U.S.P." if the label carries a declaration of its own standard of strength, quality and purity. It may be (1) an article conforming to the definition in the U. S. Pharmacopoeia except with respect to time of aging, percentage of alcohol and content of acids and esters, or (2) a mixture of (1) with grain alcohol or grain alcohol and water, or (3) a mixture of U. S. P. whisky with grain alcohol and water. It may not contain alcohol from non-grain sources nor may it contain any substance not present in U. S. P. whisky.

Diluted alcohol (from whatever source) with or without artificial flavor and color, is not entitled to the name "Whisky," however qualified, if sold as a drug; but may be sold as a drug under any other name which is not false or misleading in any particular.

If a physician prescribes "Whisky not U.S.P." and specifies the standards of strength, quality or purity desired, the prescription must be filled with a product conforming to such specifications.

— OSMJ —

—Dr. Carl W. Beane, West Manchester, has been elected a member of the Preble County Board of Health.

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ANNUAL MEETING, COLUMBUS, OCTOBER 4, 5, AND 6, 1934

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The OHIO STATE MEDICAL JOURNAL

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AS A MEDIUM OF SERVICE TO ITS MEMBERS

AUGUST 1, 1934 VOLUME XXX
Number 8

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(See Page 527, This Issue, For List of Columbus Hotels, Their Rates and Conveniences).

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Wood	F. L. Sterling, Bowling Green	R. N. Whitehead, Bowling Green	3d Thursday, monthly.
Fifth District	H. V. Paryzek, Councilor	Chrm. Com. on Arrangements	Cleveland.
Ashtabula	J. F. Docherty, Conneaut	A. M. Mills, Ashtabula	2nd Tuesday, monthly.
Cuyahoga	A. A. Jenkins, Cleveland	Clarence H. Heyman, Cleveland	3d Fri. Feb., March, May, Sept., Nov., Dec.
Erie	J. C. Kramer, Sandusky	G. A. Stimson, Sandusky	Last Thursday, monthly, except July, Aug.
Geauga	Lura E. Gordon, Burton	Isa Teed-Cramton, Burton	Last Wed. Apr. to Dec.
Huron	H. H. Ewing, Willard	J. C. Steiner, Willard	Once monthly, Feb., May, Sept. & Dec.
Lake	B. T. Church, Painesville	Mabel Pearce, Painesville	Last Tues., Monthly.
Lorain	Geo. M. Blank, Lorain	W. E. Hart, Elyria	2d Tuesday, monthly.
Medina	Harry Streett, Litchfield	J. K. Durling, Wadsworth	1st Thursday, monthly.
Trumbull	J. H. Caldwell, Warren	R. H. McCaughtry, Warren	2d Tues., monthly, Sept.-May.

Societies	President	Secretary	
Sixth District	J. D. Holston, Massillon	J. H. Seiler, Akron	2d Wed., Jan., April and Oct.
Ashland	O. J. Powell, Ashland	M. J. Thomas, Jeromesville	2nd Friday, Sept. to May.
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. B. Nelson, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	Edgar H. Knowlton, Mantua	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	P. A. Stoodt, Mansfield	D. A. Weir, Mansfield	Last Thursday, monthly.
Stark	L. A. Buenman, Canton	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	R. G. Werner, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Morton, Wooster	R. C. Paul, Wooster	2d Tuesday, monthly.
Seventh District			
Belmont	C. H. Cale, Neffs	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	Seward Harris, Lisbon	Guy E. Byers, Salem	2d Tuesday, monthly.
Coshocton	Samuel Kistler, Coshocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Geo. F. Gourley, Steubenville	John Y. Bevan, Steubenville	Last Tues., monthly.
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	W. W. H. Curtiss, Dennison	Arthur Huston, Jr., Uhrichsville	2d Thursday, monthly.
Eighth District			
Athens	C. H. Creed, Athens	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	L. E. Stenger, Lancaster	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	E. F. Hunter, Cambridge	Reo Swan, Cambridge	1st and 3rd Thursday each month.
Licking	Geo. H. Brown, Hebron	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3rd Tuesday, monthly.
Muskingum	M. A. Loebell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	James Miller, Corning	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	W. W. Sauer, Marietta	G. M. James, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec
Hocking	C. C. Lyon, Logan	M. H. Cherrington, Logan	Monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	Anne D. Marting, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	Hubert Thurman, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	R. J. Caton, Bucyrus	J. A. Agnew, Crestline	1st Monday, monthly.
Delaware	Harold Davis, Ashley	J. G. Parker, Delaware	1st Tuesday, monthly.
Franklin	Verne A. Dodd, Columbus	John H. Mitchell, Columbus	1st four Mondays monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
Pickaway	D. V. Courtright, Circleville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	H. C. Duke, Richwood	Angus MacIvor, Marysville	2d Tuesday, monthly.



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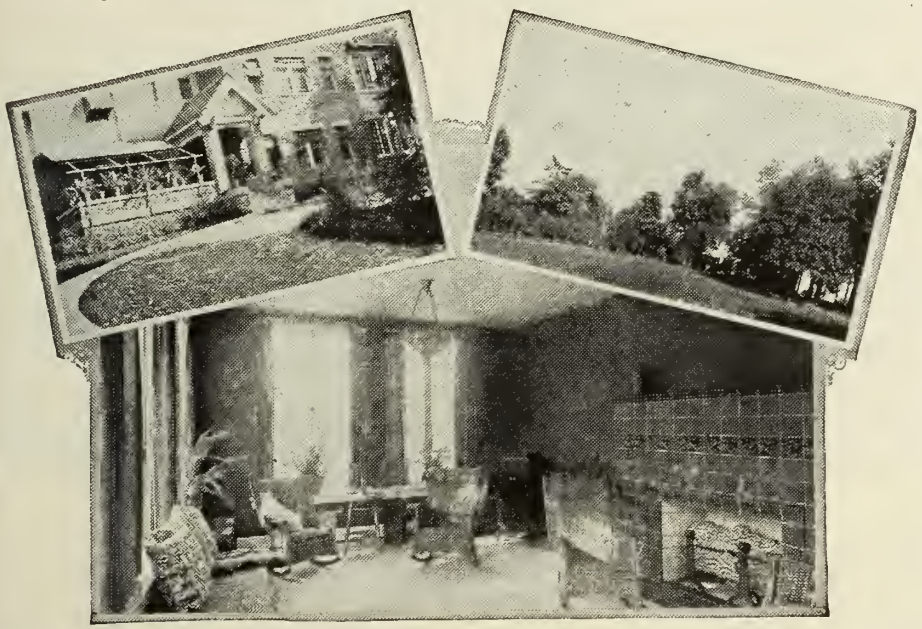


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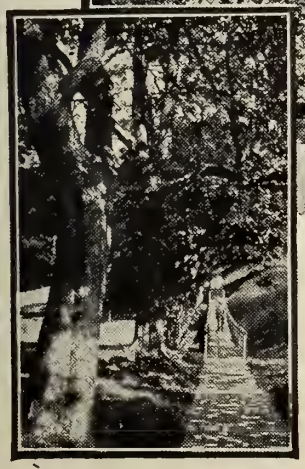
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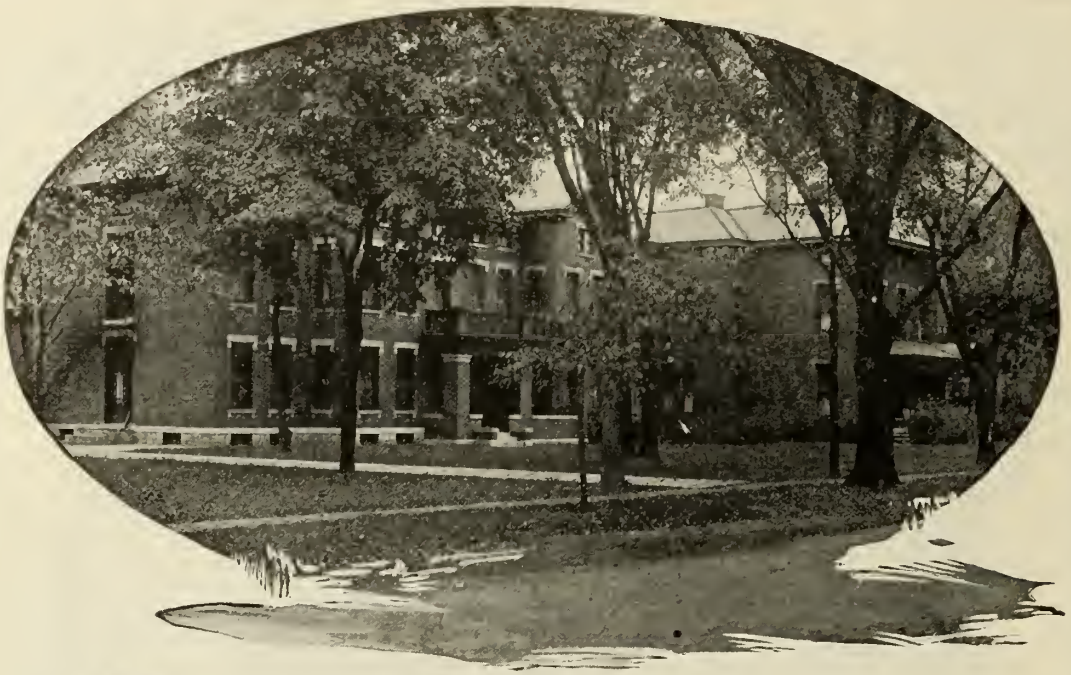




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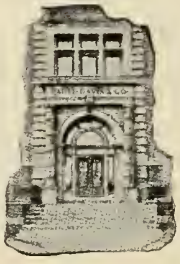
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We quote from page 54 of

"The Milk Question"

by M. J. ROSENAU, Professor of Preventive Medicine and Hygiene, Harvard Medical School.

"Man has but a single stomach and this forms about twenty per cent of the digestive tract. The cow has four stomachs which form about seventy percent of the digestive tract. The calf's stomach is well fitted to handle and digest the tough, lumpy curds which form from cow's milk. Woman's milk curdles into a soft mass which is broken into numberless small particles. Evidently the stomach of the infant fed with cow's milk is over-taxed trying to break the tough curds into particles small enough for complete digestion. It is therefore evident that even if we could secure cow's milk, the chemical composition of which was exactly the same as that of human milk, it would still be far from a perfect substitute unless it behaved similarly in the digestive tract."

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Why Starch of PABLUM *Is More Quickly Digested* than that of Long-cooked Cereals

FOR many years it has been the custom to cook infants' cereal one, two, and even three hours to increase its digestibility. This bothersome and expensive long cooking is proven unnecessary with Pablum. For, being precooked at 10 pounds steam pressure and dried, it is so well cooked that it can be served simply by adding water or milk of any temperature. Photomicrographs and also digestibility studies *in vitro* give evidence of this thorough cooking.

Fifteen cereals (both cooked and uncooked) studied microscopically were revealed as containing many starch granules, most of them massed into dense clumps. *Such unruptured clumps were never observed in hundreds of examinations of Pablum.* The latter consists, rather, of porous flakes which, like sponges, drink up liquids. Hence Pablum can be entirely saturated by the digestive secretions. This is borne out by studies of Ross and Burrill who found that the starch of Pablum is more rapidly digested than that of ordinary cereals cooked 4 hours.

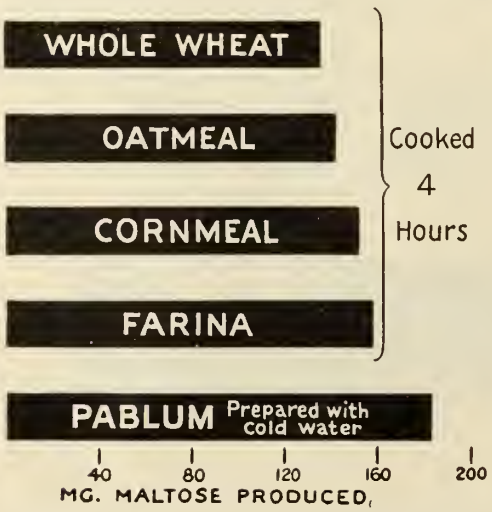


140 X. STAINED (INSET) 290 X. STAINED

Large photomicrograph: Pablum mixed with cold water—portion of large flake. Pablum flakes are honeycombed with "pores" or air-spaces (note light areas). This porosity permits ready absorption of digestive fluids by the entire flake. No starch granules appear—they have been completely ruptured.

Inset: Farina cooked ½ hour—clump of tissue including starch granules. Note density of clump and lack of porosity. Many starch granules, such as are present in raw cereal, remain unchanged in form.

Table shows that maltose production is much greater for Pablum prepared with cold water than for other cereals cooked 4 hours. Ross and Burrill (J. Pediat., May 1934) conclude from this and from the total soluble carbohydrate formed that starch digestion of Pablum is more rapid than that of 6 other cereals.



BESIDES being thoroughly cooked and readily digestible, Pablum supplies essential vitamins and minerals, especially vitamins A, B, E, and G, and calcium, phosphorus, iron, and copper. It is a palatable cereal consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, and salt.

Reprint of Ross and Burrill paper sent on request of physicians.

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

In his classical essay on "The Educational Value of the Medical Society", Sir William Osler made the following observations that cannot, we believe, be read and re-read too often by every physician:

Annual Meeting Appeal

Said Dr. Osler:

"The society acts as a professional cement between the older and the younger men. It fosters that old-fashioned courtesy which makes a man shrink from wounding the feelings of a fellow practitioner. The medical society enables a man to obtain his intellectual rating; to learn his professional assets and liabilities. Doctors don't 'take stock' often enough. We carry on our shelves stale, out-of-date goods. The society helps to keep a man up to the times; to refurnish his shop with the latest wares. It keeps his mind open and receptive, and counteracts the tendency to premature senility, which is apt to overtake one who lives in a routine. A clinical evening devoted to the rarer affections is of very great help in diffusing valuable knowledge. These teach the difficult art of observation and, what for some is equally difficult, the art of recording an observation in brief and plain language. Isolation from the general body of the profession is suicidal in the long run, for it terminates in intellectual stagnation. The medical society gives encouragement for the day's work and a betterment of mind and methods. Finally, it lays the foundation for unanimity and friendship so essential to the dignity and usefulness of the profession."

Although Osler undoubtedly had in mind the county medical society or local academy of medicine, his advice and admonitions are quite as applicable and pertinent to participation in the activities and programs of medical organization in general.

If by following Dr. Osler's advice, a physician receives the benefits that accrue from membership in his county medical society and regular attendance and participation in the scientific meetings of the society, does he not also benefit proportionately from his membership in the State Association and attendance and participation in the scientific and business meetings of the State Association held once a year? We believe the answer is obvious.

For this reason, it seems to us of vital importance that every member of the State Association who can possibly do so should plan to be present at the 88th Annual Meeting of the Ohio State Medical Association at the Neil House in Columbus, October 4, 5 and 6. What the individual county societies are to the members of the medical profession in their respective local communities, the State Association is to the profession of Ohio as a whole. If the individual physician broadens and improves himself through attendance at meetings of his local society—and he does—he also enhances his intellectual and professional status still further by participating in the annual gatherings of the State Association.

Elsewhere in this issue of *The Journal* will be found a list of Columbus hotels, together with their rates and conveniences, to guide members in making hotel reservations. It is urged that hotel reservations be made promptly. In this issue also will be found an announcement of the annual golf tournament.

The official program for the Columbus meeting will be published in the September issue of *The Journal* together with additional details and information regarding the meeting. The annual reports of the various standing and special State Association committees and officers will appear in the October issue, which will be off the press a few days early in order to give the membership an opportunity to study the reports previous to the opening of the Annual Meeting on October 4.

From every angle the Columbus meeting gives promise of being one of the best annual gatherings ever held by the medical profession of Ohio. Too much cannot be said regarding the merits of the scientific program which has been arranged by Dr. H. V. Paryzek, Cleveland, chairman, Dr. John A. Caldwell, Cincinnati, and Dr. H. M. Platter, Columbus, composing the Council Program Committee and with the splendid assistance of the Section officers.

General arrangements for the meeting have been completed by the Council Committee on Arrangements, consisting of Dr. S. J. Goodman,

Columbus, chairman; Dr. E. R. Brush, Zanesville, and Dr. E. M. Huston, Dayton.

The local committees under the general chairmanship of Dr. L. L. Bigelow are hard at work on local details and arrangements. The personnel of these committees follows:

Reception Committee—Dr. V. A. Dodd, president of the Academy, Dr. William H. Pritchard, Dr. M. D. Miller, Dr. J. F. Baldwin, Dr. Andre Crotti, Dr. George Heer, Dr. Joseph Price, Dr. C. J. Shepard, Dr. H. M. Platter, Dr. J. H. J. Upham, Dr. Wells Teachnor, Sr., Dr. Fred Fletcher, Dr. H. G. Southard, Dr. E. J. Emerick, Dr. John Mitchell, Dr. J. E. Brown, Dr. Jonathan Forman and Dr. E. F. McCampbell.

Entertainment Committee—Dr. Russell G. Means, chairman, Dr. Link Murphy, Dr. Wells Teachnor, Jr., Dr. E. J. Stedem, Dr. J. N. Jentgen, Dr. Walter Hamilton, Dr. Audrey B. Atkinson, Dr. Ruth Koons Pereny and Dr. M. Grace Welch.

Halls and Meetings Places—Dr. J. W. Wilce, chairman, Dr. K. H. Armen, Dr. John Rauschkolb, Dr. L. W. Rohr, Dr. Frank Riebel, Dr. Edward Harris, Dr. Wynne Silbernagel, Dr. Paul Scofield, Dr. Morse F. Osborn, Dr. J. E. Brown, Jr., Dr. Earl Baxter, Dr. N. C. Dysart, Dr. E. H. Ryan, and Dr. John Horst.

Projection Apparatus Committee—Dr. C. C. Sherburne, chairman, Dr. H. V. Weirauk, Dr. H. F. Fulton and Dr. G. P. Simms.

Scientific Exhibits Committee—Dr. G. I. Nelson, chairman, Dr. P. J. Reel, Dr. H. L. Reinhart, Dr. H. S. Fidler, Dr. R. W. Hoffman, Dr. E. G. Horton, and Dr. E. J. Gordon.

Commercial Exhibits Committee—Dr. Drew Davies, chairman, Dr. Richard Wallace, Dr. A. H Kanter, Dr. D. A. Minder.

Clinic Committee—Dr. Fred Fletcher, chairman, Dr. W. P. Smith, Dr. Earl Baxter, Dr. I. B. Harris, Dr. Joseph Price, Dr. Andre Crotti, Dr. Charles E. Turner and Dr. Charles A. Doan.

Women's Entertainment Committee—Dr. Edith Offerman, chairman, Dr. Grace Welch, Dr. Grace Jordan, Dr. Isabel Bradley, Dr. Emilie Gorrell, and Dr. Charlotte Winnemore.

The frame-work for an excellent Annual Meeting has been erected. Whether the hopes of those who have worked faithfully to make it so will be realized depends largely on the degree of interest and cooperation shown by the membership at large.

— OSMJ —

Political And Civic Obligations

On Tuesday, August 14, the physicians of Ohio, together with other citizens, will have an opportunity to exercise one of the important prerogatives of citizenship —selection at the party primaries of candidates for public offices to be voted on at the November general election.

With social, economic and governmental affairs in a chaotic state and the ultimate outcome of an unprecedented number of vital public questions depending on the ability, character and judgment of those entrusted with the reins of government during the forthcoming months, the primary and general elections this year are of added significance and importance.

In a recent editorial in the *Saturday Evening Post* the following pertinent questions were propounded:

"Is the man who is asking for your vote in favor of government ownership, government banking, government meddling, government regimentation under a bureaucracy, or for a minimum of government in business, with individual opportunity and freedom from tyrannical rule by government departments and bureaus? Is he for confiscation by taxation, redistribution by demagogues, or for an opportunity for everybody and anybody to accumulate honestly and without special privilege, to work for themselves as well as for the politician and the taxgatherer? Is he for free speech and free criticism of public officials whose acts, in his opinion, call for criticism? These questions are American, not partisan. They must be considered and decided by Democrats and Republicans alike."

Being well aware that the medical profession today is confronted with a crisis echoing from the strong movement toward and agitation for extensive socialization and regimentation of all business and professional activities, the physicians of Ohio dare not overlook every possible opportunity to make known their attitude on these serious questions and set about establishing additional safeguards for those principles and standards that contribute to the public's good and guarantee the professional aspects of medical practice.

Specifically, the situation so far as the medical profession is concerned appears to be one of choosing between acquiescence and regimentation by government on the one hand or active opposition and freedom of opportunity and professional practice on the other; of ignoring the concerted activities of anti-medical and anti-health groups seeking the destruction of sound and beneficial medical and public health statutes or fighting for the preservation of present high standards in the field of medicine and health.

If the medical profession desires to fight instead of run, and we believe it does, its first step should be to encourage and actively work for the selection of public officials of high caliber and sound views on all public questions, including medical and public health matters. These should include officials connected with all three branches of government—executive, legislative and judicial.

The August 14 primaries afford the medical profession an opportunity to make their influence felt and to do something concrete in political matters. They should not be regarded lightly for

they are the beginning of the weeding-out process that must take place if officials of the right sort are to be chosen.

The misconception held by many that the party primaries are merely routine and perfunctory is unfortunate. The field of candidates in this year's primaries for practically every office is large. Unless the voters exercise careful discrimination, inferior candidates may be selected to represent the parties in the general election in November.

Picking the best-qualified persons from both parties will be an unusually difficult job this year because of the large number of aspirants for practically every office. For example, there are 903 candidates for the 167 seats in the 91st Ohio General Assembly which will convene in 1935. One hundred and sixty of these aspire to occupy the 32 seats in the Ohio Senate. Only 16 of those now members of the upper body are candidates for re-nomination and re-election. Candidates for the 135 seats in the House of Representatives total 743. Eighty of the present members of the lower body are candidates to succeed themselves. The races for all other officers from governor on down are crowded proportionately.

This indicates that in all probability a majority of those in the next Legislature will be new members and that many occupying other state and local offices will be holding public office for the first time.

Inasmuch as so many of the candidates to be voted on at the August primaries are inexperienced and their attitude on some of the vital questions in which the medical profession is directly interested unknown, it is important that personal contacts be made by the physicians in each county with all likely candidates, if this has not already been done, between now and August 14.

Such contacts will give the medical profession an opportunity to know the views of candidates on questions directly affecting public health and medical practice and a chance to advise them to look to their physician constituents through medical organization for advice and guidance on medical and health questions and not to pledge themselves in advance to any measures or programs detrimental to public health and scientific medical practice. It should be remembered that candidates for public offices are more susceptible to advice before their election than after, especially that given by their own constituents.

Suggestions to the legislative committeemen of the various county societies and academies of medicine relative to the importance of these pre-election contacts and what methods should be pursued locally have been made frequently during the past few months by the Committee on Public Policy of the State Association. It is imperative that all legislative committeemen realize the importance of their responsibilities. The various societies should look to them for leadership in political matters and should require them to be on their toes in the matter of contacting candidates and keeping the membership informed on political and legislative developments. Of course, the legislative committeemen should not be expected to carry the entire burden. They should have the wholehearted and active support of the entire membership. As in every phase of organization activity, teamwork is essential to successful handling of political matters.

As already intimated, the medical profession must become more politically-minded if it expects to offer resistance to forces seeking to undermine it. Whatever political activity is undertaken should not, of course, be partisan but should be in accord with the long-established constructive, conservative and unselfish viewpoint of the medical profession which assures first consideration for the public good in all things. Neither should medical organization officially endorse or oppose candidates, but the records, attitude and qualifications of candidates should be discussed and made known.

— OSMJ —

Economy and Efficiency in Government

During the past few weeks, Ohio newspapers have published accounts of the activities of an organization composed of a number of state-wide industrial, business, financial and professional groups, known as the Inter-Organization Tax Association.

The primary object of this voluntary group of organizations representing varied interests is to stimulate public interest in and study of public affairs and to promote greater economy and efficiency in the administration of public offices.

County units are being formed to promote the purposes of the organization and obtain suggestions and recommendations for improving state and local governmental set-ups.

The purposes behind this concerted effort to awaken public interest in government and bring about constructive changes are commendable. Some may not agree with all the recommendations for governmental changes and modifications that have so far been proposed by the groups affiliated in this movement. Nevertheless, the suggestions advanced should prove useful as a basis for further study and analysis. Crystallization of public sentiment in favor of constructive changes in government is necessary to meet the critical governmental situation that has developed as a result of unfavorable economic conditions and the rapid shift of innumerable

responsibilities from the individual to governmental units.

Developments of the past few years have demonstrated that there are many governmental functions which affect in one way or another the practice of medicine. Obviously, medical organization is vitally interested in all activities that directly or indirectly affect medical practice and public health administration.

Moreover, every physician is, or should be, personally interested in having the public affairs of the state and his community administered in an honest, efficient and economical manner. The physician, like every other citizen suffers unless local and state governments function honestly and effectively and confine their activities to functions that are essentially the responsibilities of government.

Hence, the medical profession can well afford to devote thought and study to the problems of government and, when practicable and desirable, cooperate with other groups in evolving constructive ways to solve them. Physicians as leading citizens in their respective communities should feel free to express their personal opinions on such questions and take part in conferences where the good and bad features of our present governmental set-ups are subjected to critical analysis.

As a matter of information and suggestion for discussion by physicians, there follows a partial summary of some of the recommendations for governmental re-organization and improvement that have been made from time to time during recent months by individuals and groups interested in better government in Ohio:

Simplification of government.

Cooperation and coordination of activities of the overlapping units of government.

Reduction in the number of governmental units and taxing districts.

Elimination of overlapping and duplication of services between departments, commissions, bureaus, etc.

Centralized purchasing of materials and supplies.

Improvement in official personnel.

Uniform accounting for every phase of governmental activity.

Elimination of special services and functions that are not of general benefit.

Adoption of a pay-as-you-go system of financing when possible.

Pooling of equipment.

Debt control.

A constitutional limit on debt.

Restriction of special assessments.

Study of property now exempt from taxation

Study of alternate forms of county and local government made possible by constitutional amendment.

Study of the laws of Ohio to determine what sections should be amended or repealed.

Give the Auditor of State or other authority all state accounting.

Coordinate the police authorities of the state and localities.

Require property qualifications for voters on bond issues based on property taxation.

Make common pleas judges state officers and do away with such judges for each county.

Create county school districts for financial purposes.

Provide for rural municipalities, thereby giving all local functions to one authority.

Provide local option as to the abandonment of township government.

Combine health and welfare activities in each county under one authority.

Eliminate the tax levy foi teachers' retirement fund.

Tax municipal utilities when in competition with privately owned utilities.

Combine attendance and probation offices in many counties.

Reform county government by (1) combining offices and eliminating some (2) set up a county commission to run all county activities (3) estalish a county manager form of government.

Shorten the school term to 11 years.

Provide workable ways to remove officers who fail in their duties.

Require full-time salaried officials to devote their whole time to their official duties.

Do away with off-year elections and elect local officials at the time state, county and congressional elections are held.

Do away with extension work and state supported farmers' institutes.

Do away with primaries and make nominations by party conventions and initiative petitions.

Give full publicity to all bids and awards of contracts and purchases of supplies by public officials.

Reduce expenditures for pamphlets, circulars and other publicity from public sources.

Require greater uniformity of text books for schools and fewer text books.

Reform local court systems and enact a general law for municipal courts.

Limit the length of the regular sessions of the State Legislature.

Set up a non-partisan highway commission to supervise the construction and maintenance of all highways with funds supplied by motor taxes.

Abolish the Director of Commerce.

Reduce the board of clemency to two members as formerly.

As pointed out previously, these suggestions should be helpful in forming a basis for discussion. Of course, wholesale and hasty changes in state and local governments should not be undertaken. Governmental changes should be brought about gradually and only after judicious and exhaustive study of the questions involved. The above summary is a good starting point for that type of study.

STUDIES IN HEMOLYTIC JAUNDICE

By CHARLES A. DOAN, M.D., B. K. WISEMAN, M.D., and LOWELL A. ERF, M.D.,
COLUMBUS, OHIO

HEMOLYTIC jaundice is a chronic blood dyscrasia characterized by "crises of deglobulization", microcytic anemia, increased erythrocyte fragility, marked reticulocytosis, acholuric icterus and splenomegaly. First observed by Murchison in 1885 and established as a clinical entity by Hayem thirteen years later, it still remains a frequently unrecognized pathologic state, even though signs always, and symptoms frequently are present which should make the diagnosis relatively simple. The importance of recognizing this constitutional defect, when it exists, lies in the fact that a fatal relapse or exacerbation of the disease may occur spontaneously, or be precipitated by trauma or infection, in any decade of life, and that with the institution of adequate therapy, splenectomy, the clinical results are more satisfactory and permanent at the present time than in any other of the so-called primary blood diseases.

With diagnostic and therapeutic devices thus highly developed, the fundamental etiology and underlying mechanism remain nevertheless obscure, and there continues to be disagreement among physicians and investigators first, as to the importance of an hereditary background and second, as to the relative rôles of spleen (hemolytic activity of reticulo-endothelial system, clasmatocytes) and bone marrow (erythropoietic efficiency) in the production of this clinico-pathologic syndrome. The application of our more recently acquired knowledge of the physiology of the blood elements to a study of hemolytic jaundice would seem to offer an opportunity for further analysis of the problems still presenting, and the present study was undertaken some three years ago in the hope that more light might be thrown upon the fundamental hemolytopoietic aspects of this disease.

IS "HEMOLYTIC JAUNDICE" EVER ACQUIRED?

At the turn of the century Minkowski[1] recorded the familial occurrence of this type of acholuric jaundice, and since that time the appearance of the syndrome as a single, dominant, Mendelian character in certain genealogies has been established. There have been reported, however, from time to time sporadic cases of mild jaundice, hemolytic in origin, without evidence of disease in other members of the same family, which have led to a more or less general acceptance of the existence of an acquired as well as an inherited form of the disease. One of the more important recent contributions to the subject of hemolytic icterus is contained in the 1931 Hume Lectures by Lord Dawson of Penn[2]. In this survey he critically analyzes the evidence upon which the sub-division of this condition into two categories, inherited and acquired, is based, and concludes that there is little reason for assuming that any case in the strict sense is ever acquired.

Perhaps a definition of terms and an explanation of certain factual evidence will be necessary before any unanimity of opinion may be hoped for on this point. It must be recognized first of all that any one of many conditions — lues, malaria, acute infections, et al—may underlie the hemolysis of red blood cells, thereby causing an excess of pigment in the general circulation, and clinical jaundice when any disproportion between pigment production and its disposition by the liver exists. Thus as a descriptive term hemolytic icterus may be used for the designation of a retention jaundice in contrast to a bile regurgitation or obstructive jaundice, but beyond this gross differentiation it is entirely non-specific as to basic causation or mechanism. *"Hemolytic Icterus,"* on the other hand, if not otherwise qualified, has come to be applied, and should be limited, to the specific clinico-pathologic entity which is carried in the chromosome pattern of the germ plasm, and upon which the disease is fundamentally dependent for its development, though conditioned in some of its clinical manifestations without doubt by external circumstance. We believe, with Dawson and an increasing number of more recent students of this disease, that a sharper differentiation should be made between the various mechanisms responsible for the non-hereditary forms of hemolytic jaundice, designating them as "acquired", "atypical" or "pseudo", with full realization that these latter syndromes are fundamentally different, and, either only slightly and temporarily, or not at all benefited by splenectomy[3].

Some of the occasional sporadic cases, which have been reported as apparently identical with the hereditary syndrome but without a positive family history, have doubtless really represented the appearance of an inherited tendency either too mild to be noticed or entirely latent in other members of the family group. In none of the three families which we have studied was the presence of this hereditary stigma recognized, even in the clinically ill individuals, until the studies here reported revealed clearly and un-

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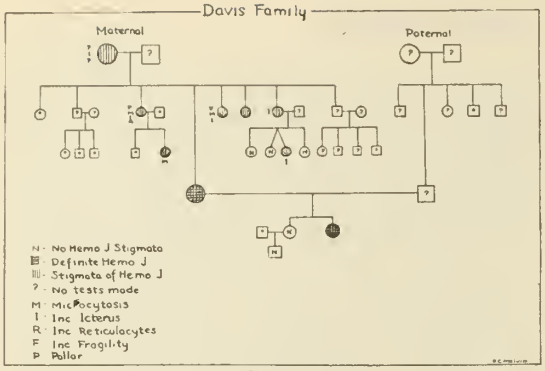


Chart 1

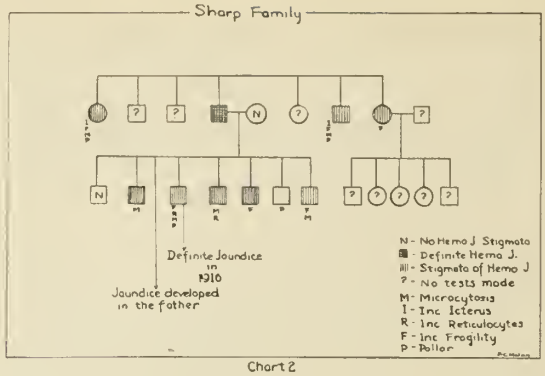


Chart 2

equivocally its existence and distribution. Obvious manifestations may be present at birth, they may first appear in any decade, or the inherited tendency may be carried and never become clinically apparent. Furthermore, the severity and frequency of clinical disease may vary widely from family to family, thus making it essential to have the requisite laboratory studies in a sufficiently representative sampling of other members of the family before an exclusion of the hereditary element is justified.

The data with reference to the incidence and distribution of hereditary stigmata in two of the families, which we have had the opportunity of studying, are given in Charts 1 and 2. In the first instance (Chart 1) it has been possible to examine and survey from a laboratory standpoint fourteen individuals in four generations, nine of whom have shown clinical or other evidence of the hereditary taint. There can be no doubt in this family that in so far as our evidence can affirm, a true inheritance of the tendency extends unbrokenly through each of the generations available for study, though not until the third of these generations was spontaneous disease sufficiently severe to produce invalidism in any individual. Splenectomy was successfully accomplished in a mother and daughter in this family.

In the second family, (Chart 2) only the patient at first and his sons later were available for direct study. Careful inquiry failed to elicit any information which might be interpreted as suggestive of the presence of the condition in other members of the family prior to its appearance in our patient. However, the fact that both clinical and laboratory data revealed the unsuspected presence of this trait in five of the seven sons, one of the stigmatized sons having been born prior to the appearance of jaundice in the father, marked the condition as familial, and suggested either its presence even though clinically dormant in previous generations, or the inheritance of an acquired character, the possibility of which Weissman forcefully denied and subsequent geneticists have continued to question. More recently three members of the patient's generation, two brothers and one sister, have come under observation and two of the three reveal both clinical and laboratory evidence of the disease. If history alone had been depended upon in this instance, though the level of intelligence and sincerity of cooperation of the patient left nothing to be desired, this case must have been considered as a possible example of "acquired", sporadic, disease cured by splenectomy.

In the third family three of four brothers and sisters of the patient showed obvious signs of the trait on clinical and laboratory examination and once again splenectomy has strikingly altered the condition of the patient.

CASE HISTORIES AND CLINICAL FINDINGS

We shall limit our analysis for the most part in this communication to two cases, though our data are quite as complete in the other cases studied.

Case I. Mrs. M. D., age 51 years, American housewife, was first seen in November, 1931, incident to certain problems of differential diagnosis in her 18 year old daughter. The daughter was found to have all of the typical characteristics of congenital hemolytic jaundice, plus an unusual, recurrent neutropenia (see Case III[1],) which has been followed both before and after splenectomy and will be presented elsewhere in detail. The mother at this time had no complaints, but was studied thoroughly in further confirmation of the hereditary nature of the daughter's condition (Chart 1). Mrs. D.'s mother, who was found at the age of 79 to have all of the laboratory evidence of hemolytic icterus, without clinical jaundice, stated that this daughter had been a "jaundiced baby". She had scarlet fever at 2; malaria at 6, with exacerbations every summer for the next 17 years; typhoid fever at 10. When 19 years of age she suffered a very severe attack of "jaundice fever" accompanied by delirium; a similar attack occurred at 23. These were the first evidences of a tendency to jaundice (hemoclastic crises) which the patient herself remembers. The patient was always able to do her own housework until her first child was born in 1906. (This daughter and her son, making the next two generations, show no evidence of the condition). For the ensuing seven years Mrs. D. suffered with little intermission from nausea, vomiting and headache, necessitating confinement to bed for a major portion of the time. However, following her second pregnancy in 1913, (daugh-

ter P. D. with marked signs and symptoms from birth) her health improved and since that time she has felt relatively normal, and has been able to discharge satisfactorily all domestic and social obligations. While otherwise symptomless periods of jaundice have recurred through the years, no serious physical incapacity has been experienced. Certain food idiosyncrasies have continued to precipitate attacks, any indigestion always being accompanied by marked jaundice, nausea and vomiting, dizziness and faintness, with stool frequently green, occasionally white, and deeply colored urine. Negative gall bladder history; menopause 1930.

On July 15, 1932, the patient fell from the third step of a small stepladder in her home and sustained an oblique fracture without displacement just below the medial condyle of the left tibia. During the succeeding four months this fracture failed to unite under the usual methods of treatment. We were called in consultation toward the end of this period. Following the accident there had been a prompt recurrence of periodic attacks of severe clinical jaundice, accompanied by the symptoms and signs just enumerated, at approximately 18-day intervals. A marked disturbance in the established hemopoietic equilibrium of the earlier part of the year was found to have occurred. The total red blood cells had fallen from around the 3,000,000 level to 2,000,000 and under, the hemoglobin from 6-7 grams to 4.5-5 grams per 100 cc. of blood; the reticulocytes had risen from 15 per cent to 25 per cent, and later rose to 35 per cent; the erythrocyte fragility remained at 0.471-0.341; the icterus index had risen from 18 to 40; the cell volume was reduced from 27 to 20; and the total white cells from 4,000-6,000 to 3,000-4,000; while the spleen had become readily palpable. In brief, every clinical and laboratory finding indicated a marked exacerbation of the hemolytic process in the body. It was our opinion that the untoward accident had precipitated, or, less likely, had coincided with a clinical exacerbation of the basic constitutional disease to an extent which prevented proper healing of the fracture even in the presence of a normal calcium-phosphorus ratio. Hospitalization was, therefore, advised for further study and a consideration of splenectomy. The patient was admitted to the Research Service of the University Hospital November 7, 1932.

The positive physical findings on admission were as follows: A white, moderately emaciated female, 50 years of age, weighing about 100 lbs., with jaundiced sclerae and a moderately deep diffuse icteric coloration of the soft, pliable skin, was confined to bed, obviously weak and ill. There was tenderness over both occipital nerve exits. The teeth had all been extracted in 1928; mucus membranes were dry, with a yellow pallor. Neither retinal nor peripheral vessels showed significant sclerosis. Heart small, ptosed, with a blowing systolic murmur over the mitral area; blood pressure 88/52; venous pressure 4 mm. No lung pathology. Abdomen protruding, with lax, atonic wall; liver at level of right costal margin and spleen palpable 2 cm. below the costal margin in the left nipple line; lower poles of both kidneys palpable. The left sub-maxillary and the left inguinal nodes were enlarged and tender; no other adenopathy. Neurological examination negative. A spiral fracture of the upper third of the left tibia was accompanied by oedema of the entire limb but especially marked at knee and ankle; the leg was in a cast with the foot inverted. The *X*-ray revealed no evidence of callous or healing. Temperature 98; pulse 80; respirations 18; height 54"; weight 106 lbs.

The laboratory data revealed negative Wassermann and Kahn reactions; E.K.G. normal; normal galactose liver function test; phenolsulphonthalein kidney function, 60 per cent first hour, 20 per cent second hour; blood chemistry, NPN 27, dextrose 66, uric acid 4.5; urinalysis, sp. gr. 1010-1015, trace to ++ albumen, no sugar, microscopic essentially negative. B. M. R. 11/11/32 plus 33; 11/21 plus 15; 12/21 plus 5. 11/21 Bl. Ca. 11.4; Bl. P. 3.2; 12/1 Ca. 10.4; P. 2.2; 12/19 Ca 10; P. 4.5. Cholesterol*, preoperative: 11/6 104; 11/18 113; 11/22 132; postoperative 11/22 123; 11/29 96; 7/29/33 180. Uric acid 11/17 4.5; 11/21 10.5; 11/23 2.1; 11/29 8.0.

On November 22 splenectomy was successfully accomplished by our colleague, Dr. George M. Curtis, the details of the operative procedure and the general surgical considerations involved being presented in the opening discussion appended to this paper. The spleen weighed 625 grams and measured 13x17x10 cm. No gall stones, and a normal liver were confirmed at operation. Convalescence was uneventful except for a slight transitory broncho-pneumonia at the left base, probably occasioned by a temporary paresis of the left diaphragm following the operative manipulation. The temperature never exceeded 102° F, and except for the effect on the red count and hemoglobin, both of which promptly dropped following their initial increases on the day of operation, contrary to our experience in other postoperative splenectomy cases, no ill effects were noted. The patient was discharged on the 30th day postoperative with definite evidence of an alleviation of the hemolytic process.

Coincident with the general constitutional improvement the oedema of the injured limb subsided. A Thomas caliper was applied and with graduated activity and weight bearing the foot was restored to normal position. As the patient was descending the stairs in her splint on the way to the hospital for examination on June 2, 1933, she again slipped and fell heavily, with a consequent fracture of both legs. *X*-ray examination revealed a fracture of the lower end of the shaft of the left femur just above the condyles, and of the head of the right tibia, without displacement in either instance. The patient was immediately hospitalized and both legs placed in plaster casts. An entirely uneventful convalescence ensued, without the suggestion of jaundice or any constitutional reaction. No oedema, which had been so prominent a part of the picture following the first fracture, developed in either leg and *X*-ray plates taken on July 26 showed satisfactory callous formation in all fracture areas, including the original ununited fracture. A general examination showed a state of health and well-being in this patient, both subjectively and objectively "unequalled in years". A detailed analysis of the blood changes will be reserved for general consideration with those presented by the other cases studied.

Case II. Mr. A. S., age 58 years, white, American, jockey and cabinet maker by occupation, was admitted to the Research Service of the University Hospital July 6, 1932, complaining of

*We are endebted to Dr. R. S. Fidler, Director of Laboratories, White Cross Hospital, for the cholesterol determinations by a new chemical method which he is soon to publish.

general weakness, more particularly of the right arm and leg, jaundice, poor memory, vertigo, pain in the left lumbar region, and difficulty in walking and talking. All of these symptoms, with the exception of the jaundice, dated from an accident on April 4, 1932, in which he was struck by an automobile, thrown some distance and rendered unconscious for one-half hour afterwards. While the patient upon recovering consciousness was able to walk home, and considered at the time that he was only badly bruised and shaken, the above syndrome developed during the week spent in bed and the patient has been completely incapacitated since.

Patient suffered no unusual illnesses during childhood. At 28 he had malaria; at 33 an appendectomy was performed during an acute attack and during the convalescence a slowly developing painless jaundice appeared. During the intervening years the patient has experienced recurrent exacerbations of the jaundice, never being entirely free of the yellow tint to his skin. He has "taken everything" to cure the jaundice but without avail. Otherwise, the patient has been in good health, "more icteric than sick" (Chaufford), and until the accident just described a fully competent expert cabinet maker and interior decorator, with a number of men under his direction and current contracts for work.

No history of clinical jaundice in any member of the family could be obtained. The maternal grandparents lived to 79 and 81 years of age, the patient's mother living to 77. Three paternal aunts and one uncle lived to be over 75. Of the patient's immediate generation, one brother died of diphtheria, one of cancer, and one was killed in France; three sisters and one brother are living and presumably well but two show clinical and laboratory evidence of the stigma. Of the seven sons of the patient, four have laboratory evidence and one clinical signs of hemolytic icterus.

On admission to the hospital the positive physical findings in the patient were as follows: A small framed, elderly, moderately well nourished and developed, white man, obviously weak and ill, and preferring to remain in bed, responded to all questions slowly, deliberately, and with difficulty both as to thought and expression, and with a definite scanning speech. The skin was definitely jaundiced, rough, moist; nail beds pale. Sclerae had a marked yellow color, pupils reacted normally to light and accommodation; slight lateral nystagmus, retinal vessels congested and fundi jaundiced; retina normal. All teeth extracted; mandible and maxillae atrophic. Left tympanic membrane thickened, some difficulty in hearing of one and a half years duration. Tongue atrophic but protruded in mid-line. No general adenopathy. The heart was slightly enlarged with a rough to and fro murmur over the mitral area; $A_2 < P_2$, pulses normal, equal, regular. Lungs normal. The abdomen protruded with a firm, hard, readily moveable, somewhat tender mass in the left upper quadrant extending to the umbilicus and beyond the mid-line, with the splenic "notch" palpable; the patient described this abdominal enlargement as of relatively recent occurrence and coincident with the deepening jaundice which followed the accident. Liver and kidneys not palpable. An old appendectomy scar remains in the right lower quadrant. All reflexes were exaggerated; right Babinski positive; no clonus. Gait, ataxic, with deviation to right, and an occasional, unexpected collapse of the right leg causing the patient to fall to the floor; Rhomberg positive, patient falling to the right. The right arm could not be raised higher than the shoulder; the grip in the right hand was much weaker than the left and none of the finer movements such as buttoning his clothes could be performed with the right hand. These motor disturbances were in marked contrast to an inherent agility and quickness which had always marked the patient's activities. The desire to read and the ability to remember were entirely lost. Blood pressure 135/68; temperature 98; pulse 70; respirations 20; weight 120 lbs.

The cytological studies may be followed on Chart 3. The other laboratory data showed a negative Wassermann and Kahn; normal galactose liver function test; PSP. kidney function, 40 per cent first hour, 10 per cent second hour; blood chemistry, NPN 33, urea nitrogen 25; urinalysis, sp. gr. 1016-1020, albumen, sugar, bile, urobiliongen and microscopic negative; B. M. R. 7/11 plus 10; indirect Van den Bergh 7/12 4.6 units; 8/11.7 units; icterus index 7/12 57, 8/1 80, 10/27 46, 10/28 31, 10/30 25, 10/31 19, 11/2 15, 11/10 15, 5/17/33 10; type IV blood group; erythrocyte fragility 0.471—0.319; ave. diam. R. B. C. 7 microns (Eve's Halometer); reticulocytes 15 per cent to 29 per cent; total red cells 2,000,000-2,500,000; hemoglobin 6.5—7.5 grams per 100 cc. blood; total white cells 2000-5000.

Diagnosis: Congenital hemolytic icterus; intracranial hemorrhage, post traumatic, with exacerbation of hemolytic process and increasing splenomegaly and jaundice.

During the subsequent three months in the hospital there was a gradual but steady disappearce of the symptoms attributable to the accident. There was a gain in weight of 22 lbs. from July 10 to October 28, and the restoration of a good measure of mental and physical vigor. The spleen, however, did not decrease in size, the icterus index remained elevated, the clinical jaundice persisted, the total red count remained below 3,000,000 for the most part with reticulocytes above 20 per cent, the hemoglobin between 7 and 8 grams, and the white cells under 5000. It was, therefore, decided to perform a splenectomy both as a prophylactic measure and to restore more completely the physical efficiency of the patient.

On October 28, 1932, a spleen, weighing 904 grams was removed by Dr. George M. Curtis without untoward incident. Convalescence was uneventful, and the patient was discharged from the hospital on November 16, the 19th postoperative day.

Two other patients have been thoroughly studied prior to and following splenectomy in our series to date, with a full confirmation of the phenomena exemplified in the cases just cited.

THE ERYTHROPOIETIC EQUILIBRIUM

The instability of the erythrocyte presents the most widely studied and most frequently recognized cellular abnormality in clinical cases of hemolytic icterus. A decrease in the average diameter of the red blood cells is more striking in this disease than in any other known dyscrasia. In 1907 Chauffard discovered the significant fact that the red cells show a markedly

diminished resistance to hypotonic salt solutions[5] and the following year reported the finding of a high sustained reticulocyte level in clinically active states[6]. This triad is practically pathognomonic of the disease. A decrease in the total number of circulating erythrocytes may occur spontaneously without demonstrable cause, or may be precipitated by infection or accident, and is always accompanied by increased icterus and frequently by an increase in the size of the spleen, as demonstrated in both Cases I and II.

During the preliminary study of Mrs. D. the effect of an intramuscular injection of liver extract, of proven potency on pernicious anemia patients, was tried[7] in the attempt to raise the red cell level. An effect opposite to that desired was observed; the red cells dropped 800,000 from the pre-injection level during four days and the hemoglobin fell 0.5 grams, each being depressed to a point lower than was seen during either of the two control periods of two months before and two months after injection. In addition, there was a general unfavorable constitutional reaction. The reticulocytes promptly rose from 14 per cent to 19.6 per cent followed by a gradual recovery of red cells and hemoglobin to their former levels but no higher. Heilmeyer[8] treated both congenital and so-called acquired hemolytic icterus with oral administration of spleen without effect; the use of liver extract either produced no noticeable improvement in the hemoglobin and erythrocyte count or increased enormously the hemolytic process as evidenced by the urinary pigment and urobilin excretion and the bilirubin content of the serum with a fall in erythrocyte and hemoglobin values. This ineffective reaction may be explained on the basis of the underlying bone marrow pathology in hemolytic icterus, which is that of an erythroblastic rather than a megaloblastic (pernicious anemia) hyperplasia. Following the fall and fracture later in the year a marked exacerbation of the hemolytic process occurred; red cells and hemoglobin fell to new low levels, 1,600,000-2,000,000 and 4.5-5.0 grams and the cell volume to 20, respectively, while the reticulocytes rose to 35 per cent and the icterus index to 40.

The improvement in the red cell level following splenectomy has usually been described as a gradual one[9], Lord Dawson citing one case as characteristic, for example, in which the red cells rose slowly from 4,000,000 to 6,000,000 during the first twenty days post-operative. Glover and Fargo[10] have, however, recently called attention in this Journal to the striking change in the cellular formula discovered six hours following removal of the spleen in their one reported case. The red cells were found to have increased from 2,160,000 to 3,144,000, the hemoglobin had risen from 46 per cent to 74 per cent, and the leucocytes from 5250 to 19,600. From our own studies it may be concluded that these authors might have found the same striking changes had they made their observations immediately instead of six hours after operation. It is the immediacy of the change, both clinical and objective, which follows splenectomy in these cases that has impressed us, and which we believe provides the basis for certain new deductions.

In our series we have taken special care to secure adequate base line observations before splenectomy, that there might be no doubt as to the relationship of the removal of the spleen to the sequence of changes which have followed so promptly in every instance. Chart 4 depicts graphically the changes which occurred, especially the dramatic shifts during the day of operation, in Case III (W. D.) During the month of observation prior to operation, it will be noted that a gradual spontaneous recovery from an hemoclastic crisis was occurring. The erythrocytes increased from 1,790,000 to 3,500,000, and the leucocytes from 5000 to 12,000. The findings immediately prior to operation on the appointed day were: R. B. C. 3,310,000, hemoglobin 7.5 grams, and W. B. C. 21,950. Fifty minutes following the ligation of the splenic artery, the corresponding data were: R. B. C. 3,700,000 (9:00 P. M. 5,500,000); hemoglobin 10.0 grams, W. B. C. 70,000. The graph then follows with half hourly to hourly determinations for the remainder of the day. The total erythrocyte count was practically doubled after splenectomy in Case I between 8:00 and 10:30 A. M., November 22d, as was the hemoglobin. The cell volume increased from 24 to 33, the erythrocyte sedimentation changed from 70 mm. in two hours to 40 mm. on the same day. In Case II, the cell volume increased from 33 to 45 and the icterus fell from 46 to 31 on the day of the operation. In Case IV (P.D.) the changes following removal of the spleen were equally dramatic; R. B. C. 2,500,000 to 4,720,000; hemoglobin 6.5 to 8.5 grams, W. B.C. 4200 to 34,000, cell volume from 25 to 35. That these phenomena did not represent a sudden increased delivery of new young erythrocytes from the bone marrow is suggested by the evidence of a reticulocyte level maintained within the preoperative limits of fluctuation. That the changes were due, on the other hand, to the elimination of the hemolytic activity of the spleen is strongly supported by the immediate decrease in the icteric index of the blood serum. Furthermore, starting on the third postoperative day (Case I), the reticulocytes began to decrease despite the development of bronchopneumonia, and a rapid decline of the red cells from the newly attained erythrocyte level of 4,000,000 to the peroperative low point of 1,990,000 by the sixth day. The reticulocytes reached 6 per cent on the sixth day and 2 per cent on the tenth day. Nevertheless, with the reticulocytes ranging from

1 per cent to 2 per cent, recovery was made to 3,780,000 red cells and 9.6 grams of hemoglobin by February, 1933.

These observations emphasize the fact that even with a high replacement reactivity on the part of the hemopoietic tissues the supply of erythrocytes is always insufficient in the clinical disease to appreciably raise the peripheral level. Conversely, given a similar low level of red cells in the same individual without the spleen, and recovery follows the subsidence of the primary etiology, in this case the pneumococcus, with a reticulocytosis never exceeding 2 per cent. In other words, at the same low level of red cells, the bone marrow is more effective with less actual production of cells than in active hemolytic icterus. Thus, the importance of the spleen in the regulation of the circulating blood elements seems assured.

Is Blood Transfusion Indicated in Cases of Hemolytic Icterus?

This phenomenon of a sudden and immediate "release" of red cells, with doubling of the hemoglobin, which we have seen follow splenectomy in hemolytic icterus cases, has a direct bearing on the question of blood transfusion in these patients. Dawson[2] warns of the dangers of preliminary transfusion in patients with hemolytic jaundice, citing two instances in his series of cases where, though the bloods of donor and recipient were most carefully typed and matched, severe jaundice promptly ensued and greatly aggravated the already serious condition of the patients. Baker and Dodds[11] have shown the serious and often fatal post-transfusion anuria to be due to the blocking of the kidney tubules by masses of acid hematin pigment. In acute hemolytic crises, therefore, the addition of transfused red blood cells from without only furnishes more material for hemolysis, with a consequent further pigmentary and toxic embarrassment of liver and kidneys, while splenectomy not only removes the major hemolytic agent, but in so doing renders once more effective the heroic efforts of the hemopoietic tissues—which compensate at the height of the emergency, with a result, the immediacy and spectacularity of which, is seldom seen in medicine or surgery. Beer[12] has called attention to the polycythemia that may result from splenectomy, stating that as high as 13,000,000 red cells have been recorded. Dawson[2] noted an eventual recovery level of 6,000,000 in one of his cases with the conclusion that "this polycythemia means that splenectomy has done more than we wanted; there was no physiological necessity to remove the whole spleen". Thus, Weinert[13] among others, has become an advocate of more conservative surgery, such as ligation of the splenic vessels. We may conclude, then, that the more severe the anemia in hemolytic icterus the greater the dangers of transfusion, and the more urgent the necessity of splenectomy or splenic surgery if spontaneous remission does not occur. Also, in other conditions of splenomegaly with anemia, where splenectomy is contemplated, the operative risk, because of the resiliency of the red cell response, is not measured as accurately by the preoperative hemoglobin level of the blood as in other surgical procedures, as we shall discuss more fully in a subsequent communication.

ERYTHROCYTE FRAGILITY

The necessity for accurate determinations of relative fragility in these and other related studies, involving erythropoiesis in diseased states, led us to a critical consideration of the technics available. The methods involving hypotonic salt concentrations are universally admitted to be unsatisfactory and subject to considerable error under the most carefully controlled conditions. Certainly they have proved unsatisfactory in our hands. We have devised, therefore, in this laboratory a new test[14], utilizing only fresh glass distilled water in addition to the patient's own blood. The real information desired is the relative stability of the homologous red cells in their own homologous plasma, and that is the principle upon which the new test is based. Two-tenths cubic centimeter of the already physiologically buffered and isotonic heparanized plasma of the patient is delivered into each of twelve agglutination tubes; fresh glass distilled water, usually starting with 0.20 and increasing by 0.02 cc. in each succeeding tube, is added; finally, 0.02 cc. of the whole blood rather than packed red cells completes the test, and the readings, made after two hours at room temperature, are reported in the salt equivalent, assuming that 0.9 gram sodium chloride per 100 cc. distilled water yields a solution isotonic with mammalian blood. The salt equivalents for the limits of normal as established by this test are 0.300—0.412. In our experience these limits have been found, thus sharply defined, so generally under normal conditions, that any deviation in either direction may be interpreted as a real abnormality. The only control necessary is the patient's own whole blood to be certain that no hemolysis has occurred in the collection of the sample. (See previous publication[14] for further details of the test).

That the phenomenon of erythrocyte fragility is inherent in the red blood cells themselves and not secondary to abnormalities in the plasma, we have confirmed. The cells from our cases of hemolytic icterus when tested against plasma from normal individuals showed hemolysis within the exact limits established by tests with their own plasma. Conversely, no increase of fragility was demonstrated for the cells from normal in-

dividuals when tested in the plasma from cases of hemolytic icterus.

We were interested in determining if there was any difference in the relative fragility of reticulated and non-reticulated red blood cells in our jaundice cases. Table I gives the original retilated and non-reticulated red blood cells in our patients on the day when a fragility test was made, and the reticulocytes determined on the residual cells at the end of two hours in each of the tubes at various hypotonic levels.

TABLE I

THE RETICULOCYTES DETERMINED IN THE SEDIMENTS OF THE FRAGILITY TEST ACCORDING TO THE WISEMAN-BIERBAUM TECHNIQUE

Plasma	Control	.471	.430	.414	.396	.380	.366	.341	.300
Reticulocytes %	22.8	20.4	9.2	10.0	7.2	9.2	23.0	12.0	5.8

The fragility of the erythrocytes in hemolytic icterus varies not only in different subjects, but also in the same individual, and though an increased ease of hemolysis is a usual finding, it is not a necessary feature nor when present pathognomonic of the disease. Lord Dawson[2] reports five of the cases in his series as having had normal fragility, and Gansslen and coworkers[15] estimate 10 per cent of the cases of acholuric jaundice to be devoid of any demonstrable increase in fragility. Five of the individuals in our hemolytic jaundice families had erythrocyte fragility within normal limits but with other stigmata of the condition present (see Charts 1 and 2). Furthermore, following splenectomy in about one-half of the cases, there is to be noted, sooner or later, a gradual return toward the range of normal for erythrocyte fragility. Lord Dawson[2] cites five of ten cases in which a marked decrease in fragility was found to have occurred within a few weeks to twelve years postoperative, though Creed in a personal communication to Dawson reports one case in which the fragility increased following splenectomy. No details, however, accompany this statement. A transitory increase on the day of operation occurred in our Case I from 0.550 to 0.582, but seven days later it was back to the preoperative range. In Case II the preoperative fragility range on several occasions and the immediate postoperative determinations were found to be 0.471-0.300, but within less than three months (January 17, 1933)

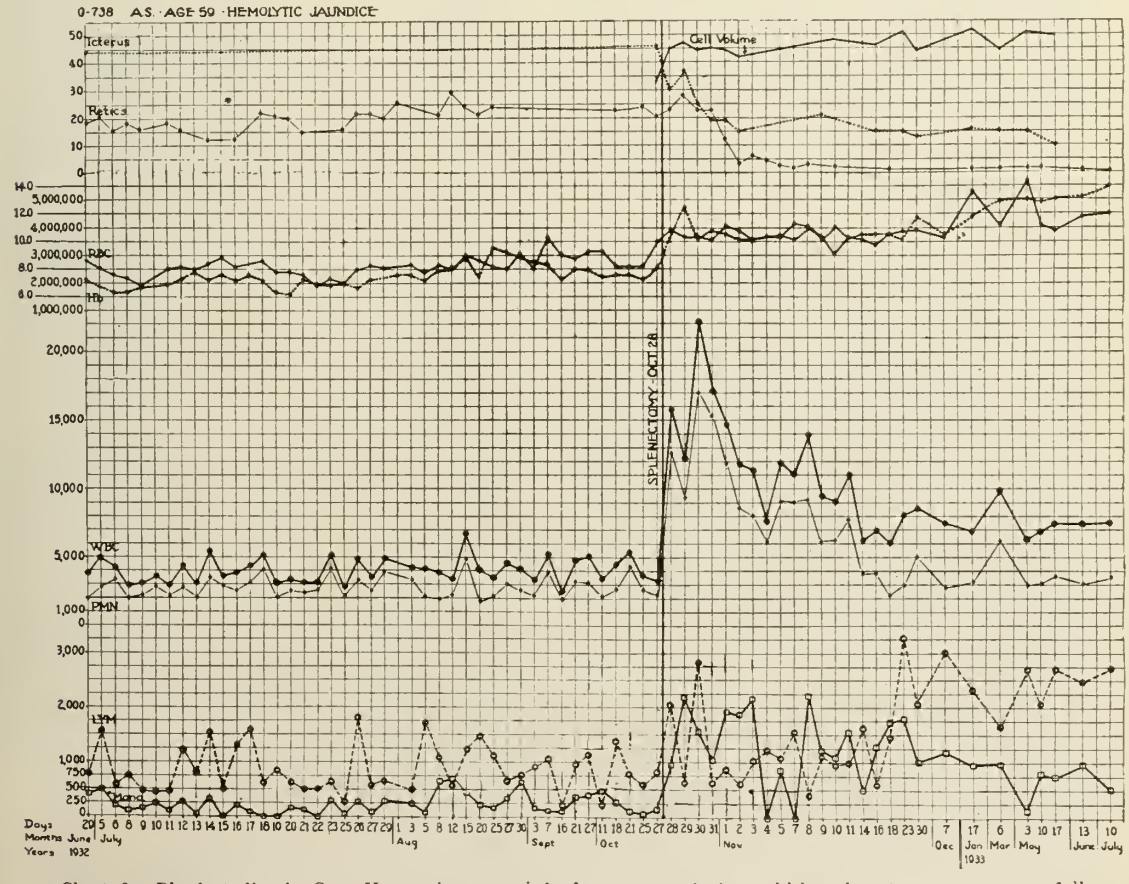


Chart 3. Blood studies in Case II covering a period of one year, during which splenectomy was successfully accomplished with a complete restoration of the patient to normal health.

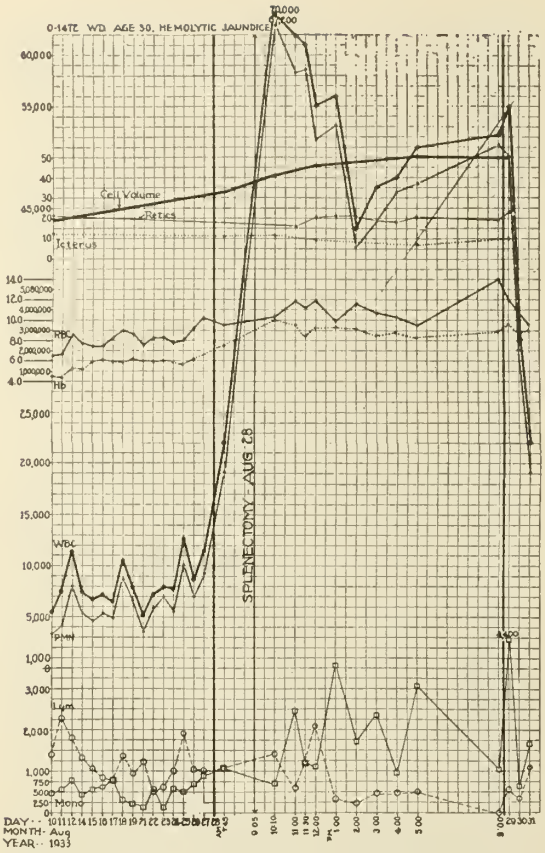


Chart 4. The dramatic changes occurring in the peripheral blood on the day of operation are here recorded following splenectomy in Case III.

after the spleen was removed it had returned to normal 0.412-0.300, and has since remained within these limits.

THE WHITE CELL EQUILIBRIA

The usual text book and clinical reports of hemolytic icterus[9, 16] describe the white count as normal or showing a moderate leucocytosis. In the cases of clinical icterus, which we have seen during the past three years, a rhythmic fluctuation of the white cells has been found showing a tendency to leucopenia and demonstrated most convincingly by regularly repeated, rather than by occasional, casual counts. The more severe the anemia the more striking the leucopenia in general, as might be expected from the bone marrow pathology, which is that of an erythroblastic hyperplasia of varying intensity.

Of 31 white counts made between Nov. 11, 1931 and March 11, 1932, in Case I, 16 were between three and five thousand and 15 between five and six thousand, the erythrocytes being between 2½ and 3 million. Of the 14 determinations just prior to splenectomy during an exacerbation of the icterus, only three were slightly above 5,000, while five were between three and four thousand, the erythrocytes being between 1½ and 2 million. Had casual and infrequent samplings only been made and had they been taken at the times when in the above series the total was 5,000 or above, the very definite leucopenic tendency would have been overlooked. Following splenectomy Nov. 22, 1932, and continuing to the present time there has been only one count under 5,000, the great majority of the white counts having remained between seven and nine thousand, the red cells being between 3½ and 4 million.

A periodic absolute neutropenia of three to five days duration has occurred regularly every 20 days in P. D. the daughter of Mrs. D., as previously mentioned[4].

During the four months preliminary study of Case II, on only six occasions was the white count found to be 5,000 or above; 14 determinations were 4000-5000; 19 were 3000-4000; 4, 2000-3000; and 1 below 2000; red count 2½ to 3 million. Since splenectomy was performed and down to the present time, the lowest white count has been 6100 with the average between 7000-8000, red count 4½ to 5½ million. (Chart 3).

Just as in the case of the red cells and hemoglobin, one of the most interesting and significant results of the leucocyte studies was the discovery of the immediacy and magnitude of the alteration in total cells following splenectomy.

Referring to Case I, immediately following splenectomy the total white count rose from 4950 to 19,475 cells, the increase in neutrophilic granulocytes being from 4059 to 17,138; in monocytes from 198 to 1558; while the lymphocyte remained essentially unchanged, 643 to 779. Referring to Case II, Chart 3, it will be noted that on the day of operation the white count rose from 3450 to 15,850, the increase in neutrophils being from 2415 to 12,680; in monocytes from 138 to 951; and the lymphocytes from 828 to 2060, though it will be seen that this was a transitory peak within the range of fluctuation observed during the preoperative control period, the average lymphocyte level remaining for some time relatively unchanged.

Chart 4 reveals the most striking change of all, the total leucocyte count having risen from 21,000 to 70,000, neutrophilic granulocytes from 19,096 to 67,200 within less than an hour of the removal of the spleen.

Just 20-21 days postoperative, in the first two patients, the neutrophilic granulocytes returned to the preoperative level, even though the convalescence in Case I had been complicated with a postoperative broncho-pneumonia. Coincident with the subsidence of the neutrophilia, and monocytosis, the curves of reaction of these cell types closely paralleling each other, an increase in the lymphocytes occurred above the preoperative and early postoperative level. In each instance the lymphocytes have continued on this newly established plateau, except in Case I when

TABLE II.

THE QUALITATIVE DIFFERENTIAL OF THE WHITE CELLS IN CASE II

Date	Polymorphonuclear Neutrophils % (Arneth-Shilling Index)						Lymphocytes % (Wiseman Index)			Total W.B.C.	Total P.M.N.	Total Lymphos.	Total Monos.
	B	2	3	4	5	6	Y	M	O				
10/18/32	7	38	40	15			9.0	48.0	43.0	4600	2760	1380	276
10/25/32	6	48	36	10			13.4	33.0	53.3	3750	2700	600	75
10/27/32	9	44	35	11			13.2	50.0	36.8	3450	2415	828	138
10/28/32 9:00 A.M.	SPLENECTOMY												
10/28/32 2:00 P.M.	23	50	24	3			15.0	50.0	35.0	15,850	12,680	2060	951
10/30/32	5	39	34	17	4	1	10.0	40.0	50.0	22,300	17,094	2886	1554
11/1/32	12	52	30	5			15.0	45.0	40.0	14,750	11,800	885	1917
11/9/32	6	56	31	7			5.5	43.4	52.1	9400	6204	1128	1222
11/14/32	10	36	38	16			8.6	45.6	43.4	6300	3906	1638	504
11/30/32	6	38	42	10	4		9.0	41.0	50.0	8650	5103	2076	1038
7/19/33	4	35	47	13	1		9.0	44.4	46.6	7600	3724	2736	532
Normal Values	4	21	48	23	4		4.0	48.0	48.0				

for a brief period following the second accident (6/22/33) the neutrophils and monocytes rose while the lymphocytes were moderately decreased.

A further qualitative study of the neutrophilic granulocytes by means of the Arneth index, and of the lymphocytes by the Wiseman index, during the period in which these cellular equilibria were shifting, is given in Table II. On the day of operation there was a transitory "shift to the left" in the polymorphonuclear cells to indicate some increased delivery of these units from the bone marrow. According to Arneth's figures for the normal there existed throughout the period represented by these data a moderate left shift. The last count on July 19, 1933, however, comes as nearly within the limits of normal distribution as it is perhaps possible to expect to record in any single chance observation. The Y:M:O: lymphocyte index was, throughout, well within the established range for normal[17]. Again a very slight "shift to the left" may be interpreted from the slightly higher proportion of "Y" forms, found about the time of operation, but no change from the normal was noted in the qualitative formula three weeks later when the lymphocytes rose and became established on their new level. We must conclude, then, that the fluctuations in total numbers of lympocytes were in this instance largely a redistribution phenomenon rather than the reflection of a changed rate of lymphoiesis[18]. That the spleen, either directly or indirectly, is influential in disturbing the various total and qualitative white cell equilibria is proved by their return to normal following splenectomy. These observations and deductions are only a part of an extended study being carried on in this laboratory on the pathologic physiology of the spleen and its relationship to erythroleucopoiesis and the cellular levels in the peripheral blood.

THE PLATELET AND SPLENECTOMY

In both of the patients around whom the major part of the discussion in this paper has centered, the platelet count was seldom above 200,000, counts of 50,000 to 70,000 having been recorded in each during the more acute clinical manifesta-

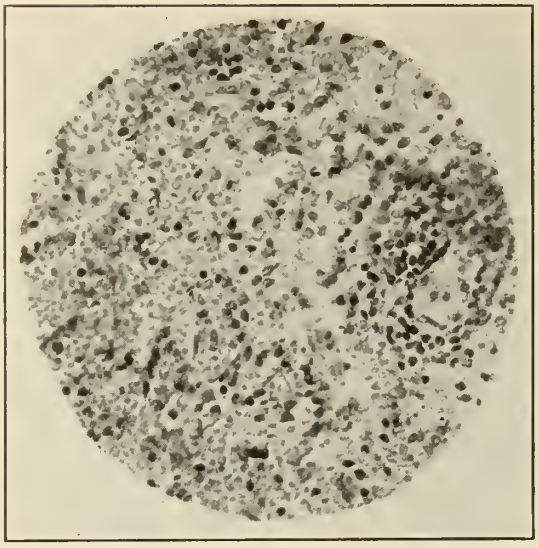


Fig. 1. Photomicrograph of the spleen from Case II. showing atrophic follicles, prominent endothelial nuclei, empty sinuses and engorgement of parenchyma with red blood cells.

tions of the disease. Following splenectomy a high point of 750,000 was reached on the 13th day with the average ranging from 300,000 to 500,000 in Case I; and a high point of 600,000 was recorded on the 12th day postoperative in Case II with a maintained average platelet count of between 250,000 and 500,000.

Similar evidence has been obtained in the past by ourselves, and not infrequently reported by others, demonstrating the influence of the spleen on platelet distribution. While the erythroblastic marrow in hemolytic jaundice often shows at least a relative decrease in the number of megacaryocytes[20] and the same reasoning may be applied to these cells as to the myeloid foci in terms of a limited opportunity for development, yet in other conditions, such as essential thrombocytopenic purpura, the bone marrow is only secondarily and moderately hyperplastic, and splenectomy relieves the thrombopenia directly and promptly. Galloway[21] studied the platelets following splenectomy in three cases of thrombopenia, in each of which the maximum increase from 90,000, 99,000, and 59,000 to 770,000, 624,000, and 1,024,000, respectively, was reached on the 11th day. In one of the cases the platelets from the splenic artery at operation were 197,000 and from the splenic vein 153,000, direct evidence suggesting that the spleen may be an important site for platelet destruction. In two of Galloway's patients seen one and two years following splenectomy the platelet counts were still much above the original levels: 581,000 and 483,000, respectively.

When the hemoclastic function of the spleen becomes accentuated beyond the physiologic limits of normal, it would seem that all of the blood elements passing into this organ suffer.

PATHOLOGY

The spleens removed in our cases ranged from 500 to 1000 gms. in weight. On gross inspection the capsules were smooth, the tissue firm, dark red in color with mottled areas of increased pigmentation. The cut surface was relatively dry with a uniform, deep maroon color, and no Malpighian bodies visible. Supravital studies of the fresh organ revealed a predominance of mature red blood cells with very few lymphocytes and a very occasional germinal center cell. Much intra and extra cellular pigment was present, the latter probably representing the content of cells ruptured in the technic of making the preparations. No erythro- or myelopoiesis was noted. Routine aerobic and anaerobic cultures were made from the spleen parenchyma, none of which showed any growth.

It is now agreed that the histo-pathology of the spleen is pathognomonic in hemolytic icterus.[2, 3, 20, 22, 23, 24, 25]

Figure 1, a photomicrograph of the spleen from Case II, shows the chief characteristics consisting of erythrocyte engorgement of the pulp, relatively empty blood sinuses, small atrophic follicle, thickened arterial wall, and prominent sinus endothelium. There is no increase of connective tissue; no visible increase in iron pigment, unless the spleen has been removed during a very active stage of hemolysis, when hemosiderin may be found to be abundant within the lining endothelial cells of the sinuses and the clasmatocytes of the parenchyma[24]. There is some difference of opinion as to the prominence of erythrocyte phagocytosis and the rôle of the reticulo-endothelial cells in the hemolytic process. However, in the hemolytic anemias the evidence increasingly points to a destruction of the red corpuscles chiefly within this group of phagocytic cells, which are most abundant in the spleen but present in both liver and bone marrow, as well as the general connective tissues. The brilliant researches of recent years[26, 27] have unquestionably established the extrahepatic origin of bilirubin. McNee[28] in 1914 made the suggestion which Rich[29] in 1924 finally proved to be correct from tissue culture studies, that it is within the phagocytic endothelium and clasmatocyte that the red cells are destroyed with the elaboration of bilirubin. In the higher mammals, moreover, the Kupffer cells of the liver play but a small part in this conversion of hemoglobin, as contrasted with the clasmatocytes of the spleen, the latter being an organ peculiarly fitted by structure and function for the task. It would thus seem probable that the "macrophages" of the spleen in patients with hemolytic jaundice are a major factor in precipitating the clinical disease.

In acholuric jaundice the liver is usually un-

altered in size, but may show large quantities of hemosiderin in the polygonal cells, and an increase in the number and size of the Kupffer cells[2, 25]. The development of clinical jaundice depends upon the excreting capacity of the liver cells. Even though the erythrocyte fragility may be high and hemolysis sufficiently active to produce a moderately severe grade of anemia, jaundice may be absent if the liver is efficient. Likewise, the kidneys show well marked hemosiderin deposits in the cells of the convoluted and Henle's tubules[11].

The bone marrow is hyperplastic and predominantly erythropoietic with normoblasts and erythroblasts rather than megaloblasts in the ascendency. Myeloid foci and megacaryocytes are scarce and widely scattered. There may be few or many mitotic figures. Both macroscopic and microscopic fat has largely disappeared. Extramedullary hemopoietic foci may occur as compensatory units indicative of the long continued and severe strain upon the ordinary sources of supply[2, 30]. No reason for the microcytosis other than the rapidity of turnover of red cells, and no explanation of the abnormal fragility is apparent from the histological study of the marrow. That the marrow may again function efficiently after splenectomy in these cases is evidenced in both Cases I and II, in the former promoting a complete recovery after bronchopneumonia from a level of 2,000,000 red cells and in the latter producing, since operation, both granulocytes and erythrocytes normal in every respect according to all known tests. A symptomatic "cure" through removal of the spleen is admittedly an accomplished fact in these cases today; and further, in some instances, all laboratory as well as clinical evidence may disappear with the removal of the spleen. The occurrence of the condition, however, marks this disease as a deep seated constitutional inheritance of the human family, and as such must be promptly recognized, and prophylactic as well as curative treatment instituted in enlightened families.

SUMMARY AND CONCLUSIONS

1. Hemolytic icterus is a disease, usually, if not always, congenital, and frequently latent for a variable number of years before clinical manifestations become apparent. Laboratory evidence of the stigma may be present throughout a long active life, without the development of clinical symptoms. For this reason, and because other hemolytic anemias may be confused with this pathologic entity, the most careful differential diagnostic studies are necessary in all so-called "atypical" or acquired cases of hemolytic icterus.

2. Splenectomy, when properly performed, brings about a prompt, usually permanent, symptomatic cure, and in occasional cases, as in one in our series, may be followed by a complete return to normal of all laboratory evidence of the condition. In "atypical" cases splenectomy is of only slight or transient benefit[3].

3. The immediacy and extent of the increase in total red cells and hemoglobin within a few minutes after the spleen has been removed is apparent in the spectacular change in the appearance and condition of the patient. The lower the red count before operation the more striking the recovery level reached on the day of operation, the red cells having been seen to increase from 2,000,000 to 3,900,000 and the hemoglobin from 5.6 to 10.1 gms. and the packed cell volume from 24 to 33, by the time and observation could be made after the actual operative procedure.

4. This immediate release of red cells is accompanied by a sharp decline in the icterus index during the first six hours postoperative, 40 to 21, and a more gradual decline in the reticulocytes from 30 per cent to 2 per cent within eight to ten days.

5. The evidence supports the conclusion that the spleen is the chief organ involved in the hemolytic process, and that the bone marrow is producing as large an increment of new cells continuously to the blood as the high reticulocytes would indicate. Furthermore, with the spleen eliminated the bone marrow has proved, in our cases, its entire competence not only to maintain the red count and hemoglobin within normal limits, but also to bring about prompt recovery from a severe anemia precipitated by an acute infection. The return to normal of the erythrocyte fragility in one case of 25 years duration, further tends to relieve the bone marrow of any major responsibility for this syndrome The unprecedented demands which are made upon the hemopoietic tissues in this disease may well in time damage their efficiency and even precipitate an "exhaustion" of the bone marrow, but the development and degree of such decompensation will always be conditioned by the original endowment of each individual with a "reserve" for any emergency, the adequacy of which, in most members of the human family, is a remarkable heritage.

6. Because of the heightened hemolytic activity of the spleen in hemolytic icterus and since we now know the rapidity of the readjustment of red cells and hemoglobin after splenectomy, preoperative blood transfusion in this disease is definitely contraindicated as well as unnecessary.

7. Liver extract would seem to be of no benefit in true hemolytic icterus, the erythroblastic rather than megaloblastic marrow hyperplasia failing to respond to this stimulus.

8. No less striking than the erythrocyte changes have been those involving the white blood cells. We have found in all clinical cases a marked tendency to leucopenia. A neutrophilic

and monocytic leucocytosis follow immediately upon removal of the spleen, and as this reaction subsides, toward the end of the third week, the lymphocytes attain a new level, more nearly within the limits of normal. The qualitative "shifts" are so slight that the reaction is interpreted largely as a redistribution phenomenon indicating readjustment of cell levels made possible through elimination of the spleen.

9. The blood platelets rose to new high levels following splenectomy in our cases, the maximum peaks of 600,000-700,000 being attained on the 12th and 13th postoperative days

10. Our studies confirm the pathognomonic character of the spleen pathology in this disease.

11. It is our belief that the evidence now available strongly points to an inherited tendency to over activity of the phagocytic mechanism (retriculo-endothelial system, clasmatocytes) of the body, centered normally in the spleen, as the basic fundamental etiology in this clinical and pathologic entity. Many factors, including trauma, infection, dietary habits, and other less obvious disturbances, condition the clinical manifestations of the disease, and cause it to run usually a chronic, recurrent, relapsing course, as in so many of the other blood dyscrasias.

DISCUSSION

GEORGE M. CURTIS, M.D., Columbus: The outstanding clinical success of splenectomy has been in hemolytic jaundice. As you have just heard, the results are immediate. There is, in the great majority of cases, obvious subsequent improvement in the condition of the patient. The operative risk is low. The studies, which you have just heard presented are, so far as I am aware, the most thorough which have ever been made upon the effects of splenectomy on the blood picture in this disease. It has been an unusual pleasure to work with this group and to observe in their studies the daily changes in the various cellular constituents of the blood. They have brought out one striking fact. Immediately following the splenectomy there is a definite rise in the red blood cell count, as well as an increase in the hemoglobin. This amounts, essentially, to an "autotransfusion."

It is of surgical interest to consider why this occurs. Ordinarily the spleen is not extensively adherent in hemolytic jaundice. As a consequence it is not much manipulated during the splenectomy. On the other hand, in our last patient, the enlarged spleen was widely adherent to the diaphragm. At the end of the splenectomy a large area of bare muscle of the diaphragm could be observed. During this splenectomy there was an unusual amount of manipulation.

These studies have added important information as to the function of the spleen in the essential nature of this disease. So far as we are aware, there is, in our present state of knowledge, no other hope for the relief of hemolytic jaundice except splenectomy. Transfusion of blood is, at best, palliative, and does not affect the fundamental cause of the disease. In fact, it is dangerous, since hemolysis of the transfused blood ensues. We have now made four splenectomies in this disease. All four patients are living, and improved, or entirely well.

For operation we prefer the left rectus incision. The left rectus may be divided through one of the tendinous inscriptions, if necessary. It is ordinarily easy to luxate the spleen. In case of adhesions, the Mayo technique, blunt dissection with a gauze pack, is indispensable. Care should be taken to avoid particularly the pancreas in putting clamps on the pedicle. It may be necessary to dissect off an adherent stomach. Paresis of the left diaphragm may be a postoperative complication. Since in all of our cases there has been an immediate "auto-transfusion," postoperative transfusion has not been necessary.

Since the indications for, and the results of splenectomy in hemolytic jaundice are so clear, it behooves every surgeon to acquaint himself with the diagnosis of this unusual disease. Clinically, the triad of jaundice, hemoglobin type of anemia, and splenomegaly is pathognomonic. To the hematologist, in addition, microcytosis, reticulocytosis and increased fragility of the red cells are characteristic. Too, it is important to remember that it is familial, and, as Dr. Doan has pointed out, usually other members of the family may be shown to have the characteristic stigmata.

The spleen is not essential to life. This has often been shown experimentally, as well as clinically. There are clinical cases on record who have survived splenectomy for twenty to twenty-five years, in perfect health. The experimental work of Paul Cannon and others has shown, however, that splenectomy reduces the resistance of experimental animals to protozoan (Bartonella) infection.

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Note: Since submitting this Mss. a total of nine splenectomies have been successfully accomplished in cases of congenital hemolytic icterus.

PYLORIC STENOSIS

By ROBERT D. HOSTETTER, M.D.,

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MY reason for discussing pyloric stenosis is to impress upon you the importance of an early diagnosis and to give you a clear understanding of the proper management of these cases. In late years there have been many excellent articles written on the various phases of this condition, yet it is very common to see babies of this type having many changes of formula with no relief—a result of improper diagnosis.

The basis of this paper is the practical knowledge obtained in a series of 92 cases. In this group I have included cases of plyorospasm, because as yet no sharp line of demarcation has been established, whereby clinically we are able to diagnose vomiting due to spasm alone or that associated with tumor. I have included only those cases where the vomiting persisted in spite of such general measures which usually control dyspeptic vomiting. There were eleven cases, eight boys and three girls classified as complete stenosis. Nine cases were operated with one surgical death. Two cases died, one in which the parents refused to have child operated; the other when first seen was in such poor physical condition, malnourished and dehydrated, failing to respond to fluid injections, was considered a poor surgical risk. The remaining 81 cases were relieved by medical treatment.

ETIOLOGY

There is some question as to the condition being congenital because clinical symptoms are rarely present at birth, most cases having their initial onset in from two to seven weeks. Cautley[1] and Dent report finding a tumor in a seven month's fetus. One of my operative cases was present at birth. It is more common in males than females —the proportion being about four to one.

The essential cause is entirely obscure but the majority of writers in Elterich's[2] opinion attribute the disorder to an imbalance of the involuntary nervous system. Aldrich[3] thinks that this might occur as a result of suprarenal impairment.

PATHOLOGY

The pathology consists of a pyloric tumor composed mainly of dense, firm, circular muscular fibers. There are no adhesions, the lumen is narrowed. The stomach early in the condition is thickened, later distended, thin and atonic.

SYMPTOMS AND DIAGNOSIS

The first symptom which appears and the most constant is vomiting. I feel that every case of vomiting occurring in early infancy and showing the following should make us suspicious of pylorospasm or pyloric stenosis and be subject to the closest observation: (1) The occurrence of vomiting in an infant who has been carefully fed on either breast or bottle. (2) Its persistence in spite of such general treatment, which usually controls dyspeptic vomiting. (3) Its forcible character. (4) Its large amount, often more than one feeding, showing gastric retention.

Whenever any of the above types of vomiting appear, it is important to determine if the two most diagnostic signs exist, which are: (1) Visible gastric peristalsis. (2) A palpable pyloric tumor. I feel it is important to say a few words as to the recognition of gastric peristalsis because these waves are only present at intervals and a cursatory examination at an improper time will mislead one. The reason for this is, that the waves depend upon active contraction of the muscular wall of the stomach and stimulation must be made to bring them out, so that the most logical time is during or immediately after the feeding. During the examination the infant must be quiet and one's hands warm, because reflex and voluntary irregular contractions of abdominal wall may be misleading. The waves start at the left costal margin and pass very slowly across the epigastrium towards the right hypochondrium, transversing the mid-line of abdomen. They vary in size from a slight elevation to the size of a golf ball, often called golf ball contractions. An important point in differentiating the false from the true waves is, that the former stops at the mid-line, whereas the true continues across. General stroking over epigastrium will often incite peristalsis. The pyloric tumor when present is felt just above the umbilicus and towards the right costal margin as a hard lump. Failure to palpate this tumor should not mislead one because the pylorus lies beneath the large liver present in the infant.

Constipation is another constant symptom; this is particularly true if of long duration, although in those cases of early complete stenosis, the stools may become scanty, liquid, and have the appearance of a starvation stool.

The loss of weight is in direct proportion to the severity of the vomiting. These infants are always hungry and accept food eagerly. This, in my opinion, is an important diagnostic point in

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differentiating vomiting due to pyloric stenosis from that due to improper feeding.

The urine early becomes decreased in quantity and highly concentrated and frequently shows a brick red uric acid sediment.

There were 32 cases in which a farina barium test meal was given to determine after a four hour interval the amount of gastric retention. The eleven cases considered as complete stenosis showed a retention of 75 to 100 per cent; whereas in the other cases there was 0 to 50 per cent retention. The severity of the vomiting and visible gastric peristalsis in some of my cases was no criterion to the amount of actual obstruction present, spasm alone being the exciting cause of the vomiting.

TREATMENT

There are a few principles in management and treatment which one can follow in this disease which have been very helpful to me, although the success of treatment depends on the condition of the infant at the time diagnosis and proper treatment is instituted.

In the cases seen early I administer atropine sulphate as recommended by Haas[4] in sufficient dosage to produce physiological effects, starting with grains 1/1000 before each feeding. During the last two years I have been using phenol-barbitol as advocated by Sauer[5] and Barnett[6] with as equally good results, the advantage being that this drug causes no marked flushing or rise in temperature, which I have found is always of great concern to the parents. There were 23 cases in my series in which this procedure alone sufficiently controlled the vomiting.

In 55 cases it was necessary to augment the above with thick cereal feedings. The amount and formula depending on the age and condition of the child. When the infant was breast fed, the cereal, one to two tablespoonfuls, was administered immediately before the feeding; whereas in the artificially fed infant it was mixed with the milk and carbohydrate and fed with a spoon, using a hygeia nipple with a large enough hole to permit the food to pass through.

When the cases are seen late I begin drug therapy and thick cereal feedings immediately and if dehydration is marked, administer fluids by rectum or hypodermocylsis. A farina barium test meal is given to determine the amount of gastric retention.

When the vomiting continues and there is a continued loss of weight, together with marked gastric retention, I recommend operation. The operation of choice is the Rammstedt operation. No case should be operated when the infant is in a state of marked dehydration because death is certain, a delay of 24 hours to 36 hours to restore body fluid balance is most beneficial. This can be administered by hypodermocylsis or intravenously in the form of glucose saline, Ringer's or Hartman's solution.

In the post-operative care it is important to sustain normal body heat and continue the administration of fluids subcutaneously in the more desperate cases. Water by mouth in teaspoonful doses may be started within a few hours after operation. Breast milk or a weak milk formula may be started within 12 hours.

In all cases I have the mother keep a record of the amount and time of vomiting at each feeding and a daily check on the weight. These infants should be handled as little as possible and kept in a quiet atmosphere. When water by mouth incites vomiting, it can be given by rectum in the form of saline solution.

The duration of the drug therapy and thick cereal feeding depends entirely on the individual case. I have found that the gradual elimination of drug therapy and the decrease in the amount of cereal used has given the best results.

Barbour[7] reports roentgen ray treatment of the upper part of the chests of 37 patients, who failed to respond to internal therapy. In 33 cases the vomiting and visible gastric peristalsis practically subsided immediately. In his opinion no case should be operated before a therapeutic roentgen test is given. In a series of fourteen cases irradiated, there were only three infants I felt were benefited by this treatment. Three of my operative cases failed to respond to irradiation.

CASE REPORTS

Case 1—W. W., a male, age two months, weight 8 pounds, 5 ounces; birth weight 8 pounds 8 ounces. At two days old was irradiated for enlarged thymus. The onset of vomiting was at about eight days of age. He would vomit immediately after feeding and often would continue to the next feeding, at times projectile. The mother stated he was fretful, restless, slept poorly and would take all the milk and water he was given. Breast fed for six weeks, then taken from the breast, because milk did not agree. At the time of my examination, was receiving milk 13 ounces, water 11 ounces, and dextra-maltose 2 level tablespoonfuls, 6 feedings of 4 ounces each, at 4 hour intervals. Physical examination except for a slight degree of undernourishment was negative. There were visible gastric peristalsic waves, but no palpable tumor. The administration of atropine sulphate grains 1/1000 before each feeding sufficiently controlled the vomiting, so that with an increase in strength of the above formula, this infant over a two months period showed a gain of 4 pounds and 6 ounces.

Case 2—R. V. D., male, age eight weeks, weight 5 pounds, 6 ounces; birth weight 6 pounds. The onset of vomiting at 28 days of age; prior to this time was apparently normal and gained weight to 8 pounds 2 ounces. At first the vomiting occurred only after an occasional feeding but gradually increased in frequency and severity, so that when first seen had projectile vomiting after each feeding. At 35 days of age was removed from the breast because milk did not agree and was

placed on three different formulas with no relief —even water incited vomiting. Was receiving Dryco 1 tablespoonful, water 2½ ounces, 7 feedings a day, practically a starvation diet. The infant was fretful, slept poorly and would always take food eagerly. Constipation was marked, stools were small and hard, requiring daily enemas. The physical examination revealed a poorly nourished infant, visible gastric peristalsis but no palpable tumor. The diagnosis was based on the failure to stop vomiting with frequent change of food, visible gastric peristalsis, constipation and character of the appetite. Atropine sulphate grains 1/1000, before each feeding consisting of cow's milk 10 ounces, water 11 ounces, and dextri-maltose 2 level tablespoonfuls—7 feedings a day of 3 ounces each, over a period of 48 hours showed no decided improvement in the vomiting. He was then given a thick cereal feeding prepared as follows—the above amount of milk and water was brought to the boiling point and 4 tablespoonfuls of uncooked farina was added—this was cooked slowly for 40 minutes over a direct flame, after which the dextri-maltose was added. He was fed with a spoon through a hygeia nipple 3 rounded tablespoonfuls 7 times a day. There was a decided improvement in the vomiting, so that in one week's time there was a gain of 12 ounces. It was necessary to continue the above treatment for a period of three months during which time there was a gain of 7½ pounds.

Case 3—R. T., male, age eight months, weight 6 pounds 4 ounces; birth weight 7 pounds. The onset of vomiting was about four weeks of age; prior to this time was apparently normal and gained weight. There were very few feedings after which he did not vomit from a few ounces to the entire feeding. When retained the amount of vomiting at the next feeding was often more than the amount taken at the feeding. It always contained a large amount of mucus. At six weeks of age was taken from the breast and was given eight changes of formula with no apparent change in the vomiting. Stools were hard and small, requiring daily enemas. The urine was scanty and highly colored. The baby was very fretful and had a ravishing appetite, always crying after each feeding. The physical examination revealed a very marked degree of marasmus, the abdomen was retracted and there were visible gastric peristaltic waves the size of an English walnut; a pyloric tumor was palpable—the heart and lungs were normal, Wassermann and tuberculin tests were negative. The farina barium test meal showed a 50 per cent retention after a four hour interval. This case was given up as hopeless by the family physician. The treatment consisted of the immediate administration of Hartman's solution by hypodermocylsis. In 48 hours he took 2200 cc., the fluid being readily taken up on account of the marked degree of dehydration. He was given atropine sulphate grains 1/1000 before each feeding and this was increased to grains 1/500 before vomiting was controlled. The formula consisted of cow's milk 16 ounces, water 16 ounces, dextri-maltose 2 level tablespoonfuls and uncooked farina 6 tablespoonfuls. He was fed 6 tablespoonfuls every 4 hours, 6 feedings a day. Due to the large amount of mucus present in the vomitus, gastric lavage was done twice a day for a period of one week. As water incited vomiting it was given by rectum in the form of saline solution for a period of 16 days. In 5 days time there was a gain of 25 ounces. He was under treatment for a period of 5 months and 26 days during which time there was a gain of 14 pounds and 7 ounces. At two years of age the weight was 28 pounds and there was no vomiting during the previous 8 months.

Case 4—C. J., female.—First seen at three days of age with history of vomiting since birth; the nurse observed that at times it was projectile in character. Due to the vomiting the infant had only received a 5 per cent glucose solution, which she never refused. The birth weight was 7 pounds 3 ounces, by the third day there was a loss of 15 ounces. On examination she appeared bright and active, color was good and had a fairly strong cry. She was given a bottle of 5 per cent glucose which was eagerly taken, there was no difficulty in swallowing; observation revealed visible gastric peristalsis. The treatment consisted of immediate irradiation over the thymus gland, atropine sulphate grains 1/1000 every three hours, a feeding of breast milk and 5 per cent glucose 1 ounce each, every three hours and normal saline by hypodermocylsis. At the end of 24 hours she was still vomiting and a loss of 4 ounces in weight. One rounded tablespoonful of cooked farina was added to each feeding. A barium test meal showed about 60 per cent retention after a four hour interval. On the fifth day there was still no decided improvement in the vomiting and another loss of 5 ounces. I recommended operation on this day because there was no decided improvement in the vomiting, the continual loss in weight and the degree of gastric retention. I felt that this small infant could not continue indefinitely on medical treatment with no improvement and still be a good surgical risk. The operation revealed a typical pyloric tumor. The recovery was slow and there was occasional vomiting for about three months, weight being 10 pounds 3 ounces. At one year this child weighed 20 pounds and 13 ounces.

HISTORY OF MY OWN BOY

Case 5—R. D. H., Jr., born Nov. 26th, 1923. Weight 9 pounds 4 ounces. On dismissal from hospital at 17 days weighed 9 pounds 8 ounces. Onset of vomiting on the 24th day when it occurred rather suddenly and it was thought he had an acute gastro-intestinal upset. Prior to this time was apparently normal. I saw the baby on the 27th day, as he was born in the East. In the interval shortening of breast feeding to 3 minutes and increasing interval from 3 to 4 hours, together with plain barley water had no effect on the vomiting, it was persistent and projectile. At times he would retain a feeding but at the next feeding would vomit a larger amount than just given, showing gastric retention. He cried all the time and was always hungry. Bowel movements were small, dark green and liquid, and contained considerable mucus. Urine was scanty and highly colored. There were typical gastric peristaltic waves the size of a golf ball, a tumor was palpable.

Treatment was instituted after examining the infant and consisted of atropine sulphate, thick cereal feeding and gastric lavage twice a day as vomitus contained considerable mucus. On the 29th day a farina barium test meal showed no barium passing through the pylorus over a 12 hour interval. On the 30th day I took him to the Children's Hospital in Philadelphia. I was particularly careful to keep up body fluid balance and gave saline solution by rectum and hypodermocylsis. On the 31st day a Rammstedt

operation was performed, which consisted of a right rectus incision; a pyloric tumor about 1½ inches long and 3/4 inches in diameter was found beneath the liver; it appeared pale and very hard to the touch. An incision was made along the avascular border and separation of the tumor was made with a blunt haemostat from the stomach to duodenum down to the mucus membrane along its entire length. Nothing else was done to the pylorus, the peritoneum, subcutaneous tissues and skin were then sutured. It is important that all fibers of the tumor be separated, because incomplete separation may necessitate a second operation; also care must be exercised when the fibers adjacent to the duodenum are separated because the tumor ends abruptly and rupture of the mucus membrane is not uncommon. He made an uneventful recovery and is none the worse for this early experience.

SUMMARY

First—Differential diagnosis between pylorospasm and pyloric stenosis is clinically impossible.

Second—All cases of persistent vomiting, especially in male infants and occurring between the second and seventh weeks should be under the closest observation.

Third—The symptoms and signs are persistent and projectile vomiting, visible gastric peristalsis, a palpable pyloric tumor, constipation and loss of weight.

Fourth—Treatment consists of the administration of atropine sulphate or phenol-barbitol, thick cereal feedings and irradiation. No case should be treated surgically without giving medical treatment a fair trial.

Fifth—No infant should be permitted to become extremely dehydrated by failure to supply necessary body fluids.

Sixth—The Rammstedt operation is the operation of choice.

DISCUSSION

J. VICTOR GREENBAUM, M.D., Cincinnati:—We should be pleased that Dr. Hostetter has reopened the subject of pyloric stenosis because this condition, although rare, should always be borne in mind in the case of infants who vomit. I agree with Dr. Hostetter that the cause of congenital hypertrophic stenosis of the pylorus is probably due to prenatal causes. Ten years ago, Dr. Steinharter and I reported a baby who showed symptoms of this condition immediately after birth and which was relieved by operation. The infant was 57 hours old at the time of the operation.

I made the statement above that congenital hypertrophic stenosis of the pylorus is a rare condition. This has been our experience in Cincinnati where, at the Cincinnati General Hospital, during the past twelve years in a total admission of over eleven thousand of pediatric cases there were only fourteen cases of this condition noted. A summary of these cases present some interesting findings. The age of these fourteen cases varied from one day to eight weeks; six were white and eight were black; all were males; four weighed more than the birth weight and ten less; thirteen had projectile vomiting; the pyloric tumor was felt in six; peristaltic waves seen in twelve; stools in all were normal; thirteen were operated upon; one was treated medically; four died of which three were surgical cases and one medical; three autopsies were performed which confirmed the diagnoses; the thymus was normal in size in two of the cases in which *X*-rays were taken; the gastro-intestinal tract was negative from an *X*-ray standpoint in two and positive in six; all were breast-fed; the time in the hospital varied from 13 to 98 days; the complications consisted of pneumonia, otitis media, cardiac failure and intestinal obstruction necessitating gastro-enterostomy in one, three weeks after the original Rammstedt operation. It was interesting to note that the child treated medically showed no obstruction by the *X*-ray examination but had a definite pyloric tumor on autopsy.

In contrast to the small number of pyloric stenosis cases, there were hundreds of cases diagnosticated as pyloric spasm during this same period of time at the Cincinnati General Hospital. Of these 22 were proved cases. The interesting findings of this group were: ages varied from one day to sixteen weeks; four were black and eighteen white; seven females and five males; eight weighed more than the birth weight and fourteen less; projectile vomiting was present in twelve; a tumor was felt in none; peristaltic waves were seen in ten; the stools were normal in all; one was operated upon and the rest were treated medically by various methods; five died; autopsies were performed on two showing normal pyloric openings; the *X*-rays showed the thymus enlarged in two; positive *X*-ray findings in the gastro-intestinal tract in six and negative in six; time in the hospital varied from four to 200 days; the complications were not remarkable; eleven were breast-fed and the others had various types of feeding.

On the basis of these two series it is evident that pyloric stenosis may be present with or without spasm, which condition is due to irritation of various kinds. It is practically impossible at the outset to distinguish these conditions. As Dr. Hostetter has brought out, the proper procedure is to treat the infant medically in order to relieve the spasm of the pylorus. The description of his cases and the treatment he employed should be an example to us of the patient, watchful care which should be given to these infants.

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THE SIGNIFICANCE OF ABDOMINAL PAIN FROM THE STANDPOINT OF THE UROLOGIST

By FRANK W. HARRAH, A.B., M.D., F.A.C.S.,
COLUMBUS, OHIO

IN interpreting pain in the abdomen, there are a large number of possibilities that it is essential to keep well in mind.

I want here to consider the most common lesions of the urinary tract that give rise to pain in the abdomen and to point out, where possible, the means by which they may be recognized or, at least, the features that should make one suspect them.

Urologic lesions give rise both to constant pain and to pain in crises, to local pain and to pain that is referred. It may be of all varieties, dull, boring or colicky.

RENAL COLIC

Renal (or ureteral) colic is the most characteristic pain originating in the upper urinary tract. This pain is due to spasmodic contractions of the muscles of the renal pelvis or the ureter, and, like all muscle-contraction pains, is inconstant in severity, varying not only from person to person but from time to time in the same patient. The pain comes on in sudden attacks, it may be localized or diffuse, and is frequently referred to other points in the abdomen, sometimes to the scapular region. The pain radiates downward; along the course of the ureter, if the contractions start high up; into the external genitalia and the thigh and leg of the same side, if they originate in the lower part of the uterer, but they are not always typical. After the severe pain has subsided, there may remain an aching in the kidney region. These agonizingly painful muscle contractions may be caused by the passage of stones, tumor fragments, parasitic cysts or blood clots into and through the ureter. They can occur in any disease of the kidney in which hemorrhage takes place, but, more especially, they characterize ureteral stone.

Such attacks can simulate acute intraperitoneal catastrophies. Shock, nausea and vomiting may be present and there may be marked spasm of the abdominal muscles on the side affected. It is sometimes possible to elicit tenderness by palpation over the pyloric end of the stomach or the gallbladder region. The history is of great importance in differentiating urologic from intra-abdominal lesions and should be of value in deciding between renal colic and perforation of a gastric or duodenal ulcer. In the latter conditions, furthermore, the patient is in a state of more intense collapse, with pulse more rapid, smaller, thready, and face more pinched. Restlessness is seen earlier in renal colic, and in colic there is no clouding of the mind.

Constipation and scanty, high colored urine are common both to diseases of the urinary tract and to intra-abdominal lesions. But the presence of blood or of pus cells—few or many—in the urine demands definite explanation in every case. A thorough urinalysis, with careful *attention paid* to the laboratory report, would save much unnecessary exploration of the abdomen. While blood in the urine points strongly to the urinary tract, this may be present in certain intra-abdominal conditions, such as intestinal obstruction and appendicitis. Confusion with intestinal obstruction can occur in cases of renal colic in which the pain is diffused and localizing symptoms are lacking, especially since this type of renal colic is likely to be accompanied by abdominal distention, vomiting and absolute constipation. The order of appearance of the phenomena helps here, constipation appearing first in intestinal obstruction and pain being the earlier symptom in renal colic.

The diagnosis of lesions of the upper urinary tract becomes more complicated when it is the right side that is affected, for on this side the gallbladder and appendix come into the question. It is far more common for renal lesions to be mistaken for disease of the gallbladder or appendix than for the error to be the other way about. Remember that in biliary colic the pain will be most intense anteriorly and will tend to radiate upward, and that there will be rigidity in the upper portion of the right rectus muscle, which is not found in renal colic. In biliary colic there will be no blood in the urine.

If the question lies between renal colic and appendicitis, pressure over McBurney's point can be useful. This point is often comparatively painless in renal colic, but care must be taken not to mistake tenderness over the ureter where it crosses the brim of the pelvis for tenderness over this point. In appendicitis the muscular rigidity is greater, the pulse more rapid, and the constitutional symptoms more severe. Pressure over the descending colon, in an upward direction, increases the pain in appendicitis, but not in renal colic. If the urine does not show pus, leukocytosis speaks strongly in favor of appendicitis as against a urological lesion, but pus in the urine wipes out the value of this symptom for differentiation. Pain in the loin is a valuable indication of renal colic, but of greater value in distinguishing it from gallbladder disease than from

appendicitis, for it is sometimes present in the latter condition. A characteristic of urinary tract stone is that the pain is made worse by exercise, more especially by jolting.

The fixed pain of a stone impacted in the ureter is a dull, heavy ache, most often felt in front, which can be mistaken for disease of the gallbladder or for chronic appendicitis, according to the point to which it is referred.

HYDRONEPHROSIS

The pain of hydronephrosis differs from that of stone colic. It comes on gradually and it subsides more slowly. Between attacks, the health is good. This condition may be confused with an enlargement of the gallbladder or spleen or with a tumor of almost any of the intra-abdominal organs, a retroperitoneal or an adrenal tumor, or an aneurysm of the renal artery or of some other abdominal artery. On the other hand, there may be no palpable swelling, for a very painful hydronephrosis may be small, or, if large, it may be flaccid, or it may not descend below the ribs. With abdominal pain, nausea, vomiting, little or no fever—all typical symptoms of a hydronephrotic crisis—such cases are frequently taken for appendicitis. There are no bladder symptoms in hydronephrosis to call attention to the urinary tract. Acute hydronephrosis (Dietl's crisis) could at times be confused with torsion of an ovarian cyst; one should note the height of the mass and should inquire for a history of recurrence.

PYELITIS

Pain on either side of the abdomen during pregnancy at once suggests pyelitis; if it is referred to the costovertebral angle, this supposition will be strengthened. In spite of the extremely high temperatures that may be reached, the patient with pyelitis does not appear as ill as the patient with acute appendicitis; also, the pain is not so severe nor so constant, the pulse and the leukocyte count are nearer normal, rigidity is not so great.

There are numerous other conditions in the kidney and ureter which must be borne in mind when one is confronted with pain in the abdomen: tumors, infections, movable kidney, traumatic injuries, ureteral kinks and strictures, and anomalies of structure, such as double kidney and duplication of the ureter. I recall the case of a man who had had his gallbladder removed for chronic cholecystitis, so called, had been operated on again for chronic appendicitis and a third time for postoperative adhesions; but still the pain persisted, and when he was finally referred to me we found that he had two kidneys on the right side, which were causing all the trouble; after their removal he had no more pain.

This brings me to those cases of renal and ureteral disease, particularly numerous, that masquerade for years as chronic appendicitis, chronic gallbladder disease, or adhesions, which are operated on again and again, but in which the pain survives all the operations; or, again, those cases which defy every attempt to fasten a name upon them and come sooner or later to the operating table for exploratory laparotomy—unless someone along the line thinks to order a urologic examination. Hess[1] has recently stated that he had in his own experience a series of eighty consecutive cases of renal or ureteral stone in which only two of the patients had escaped one previous abdominal procedure, and some had had as many as five abdominal operations. This, he rightly states, "should cause us all to prick up our ears and be alive to a very serious situation." In these vague cases, we cannot rely on the description of the pain, renal pain is not sufficiently characteristic, either in its nature or in its location; we cannot rely on the history or on the physical examination, to rule out a urologic lesion. It is only ureteral catheterization and pyelography that can settle the doubt.

Passing on to the lower urinary tract, we have the bladder, the prostate and the seminal vesicles that can give pain that will simulate abdominal disease. Bladder pain, for instance, may be localized to the hypogastric region, and it is not in every case accompanied by urinary frequency. It may be caused by inflammation, by tumor, or by stone, or by tumor of a neighboring organ pressing on it. For stone in the bladder, the same as for stone in the ureter, aggravation of the pain by jolting is a useful sign.

Rupture of the bladder, especially if nontraumatic, may cause considerable uncertainty in diagnosis. Commonly there are urinary symptoms, but in occasional cases there is nothing to point to the bladder, the patient complaining only of the symptoms of diffuse peritonitis. A case was recently reported[2] in which the day following a traumatic bladder rupture, the patient was so unconscious of having received a critical injury that he went on foot to the physician's office, and the physician, equally unconscious of an emergency, allowed him to continue on foot to the hospital, where it took a cystoscopy to clear up the situation.

Chronic prostatitis may be responsible for the greatest variety of pains, felt "anywhere below the diaphragm," and simulating appendicitis, gallbladder disease, renal colic, etc.

Hess[3] cites a case of left seminal vesiculitis, which was diagnosed and operated on as acute intestinal obstruction; there was pain localized just above Poupart's ligament, obstinate constipation and vomiting.

There is still another manner in which the urinary tract may become mixed up in the complexities of abdominal pathology and increase the difficulty in interpreting the symptom of pain.

Lesions of one system may coexist with lesions of another; they may both be traceable to the same cause, or one may have given rise to the other, or there may be no etiologic connection between them, but one aggravates the other and keeps it active. Thus, movable kidney and dilatation of the stomach are frequently found together. The reason for this may be mechanical obstruction of the gastric outlet, or it may be a constitutional tissue weakness affecting muscle as well as connective tissue. Likewise, the movable kidney may compress the intestine, with consequent dilatation of the proximal segment. Movable kidney with hydronephrosis can cause intermittent ileus.

Tumors and cysts of the kidney, dilatations of the renal pelvis or a greatly enlarged kidney can compress the neighboring parts of the intestine, especially the duodenum, ascending and descending colons, and result in phenomena of stenosis. By reflex impulses over the splanchnicus, kidney stone colics, acute hydronephroses, suppurative nephritis, or massive hemorrhage into the bed of the kidney can give rise to functional disturbances of passage in the intestines: intestinal atonies and paralyses with meteorism, or, instead of atony, spasm. Infections of the gallbladder or appendix may travel to the kidney and result in nephritis or in pyelitis. Stubborn cases of pyelitis have been cured by appendectomy. If there is no operation, the pyelitis may remain after the attack of appendicitis has subsided. Also, a latent appendicitis can act as a focus of infection for a pyelitis, which will defy all treatment till its origin is recognized.

Once started, the chain of complications in the abdomen may go on almost indefinitely: thus, a hydronephrotic kidney compresses the intestine, the intestinal stasis sets up infection of the kidney, the infected kidney becomes fixed in an abnormal position; the pericecal reaction provokes adhesions and even retrocecal and retro-ureteral infiltration.

The writers of our text-books have been at pains to simplify each clinical picture before presenting it to us. But life is not like this. In life we have in all cases an interaction of one organ and of one function on another. The matter of this interaction can never be ignored; it is for the clinician to decide how great or how small is its importance for the individual case before him. But if the specialties are to guard their usefulness and to hold the confidence of the people and the respect of the medical profession as a whole, they must each be ready, as the need arises, to look beyond their own limits and to appreciate the interweaving of systems and functions.

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— OSMJ —

New Books Received

The Medical and Orthopaedic Management of Chronic Arthritis, by Ralph Pemberton, M.D., F.A.C.P. professor of medicine, Graduate School of Medicine, University of Pennsylvania, and Robert B. Osgood, M.D., F.A.C.S., professor emeritus of orthopaedic surgery, Harvard Medical School; a practical exposition of the subject of chronic arthritis for internists, including general practitioners, and orthopaedic surgeons, in which the authors support in a concrete manner their convictions that chronic arthritis is largely a preventable and curable disease; The Macmillan Company, 60 Fifth Avenue, New York City, publishers; price $5.00.

Spinal Anesthesia, Technic and Clinical Application, by George Rudolph Vehrs, M.D., Salem, Oregon; a survey of the experimental and clinical records in the field of spinal anesthesia for the past 40 years; The C. V. Mosby Company, 2523 Pine Boulevard, St. Louis, publishers; price, $5.50.

Surgery of a General Practice, by Arthur E. Hertzler, M.D., professor of surgery, University of Kansas, and chief surgeon, Halstead Hospital, and Victor E. Chesky, M.D., chief resident surgeon, Halstead Hospital; The C. V. Mosby Company, 2523 Pine Boulevard, St. Louis, publishers; price, $10.00.

Manual of the Diseases of the Eye, by Charles H. May, M.D., director and attending surgeon, eye service, Bellevue Hospital, New York, 1916-1926; 14th edition, revised, of a treatise for the student and the general practitioner, supplying the foundation to which further knowledge may be added by reference to more extensive and comprehensive text books; Williams & Wilkins Co., Mt. Royal and Guilford Avenues, Baltimore, Md., publishers; price, $4.00.

The Dangerous Age in Men, by Chester Tilton Stone, M.D., New York City; a treatise on the prostate gland especially for laymen; The Macmillan Company, New York City, publishers; price, $1.75.

POLICY, ORGANIZATION, ANNUAL MEETING AND PROFESSIONAL PROBLEMS CONSIDERED BY COUNCIL AT JULY MEETING

MINUTES

The Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, at 1:00 P. M. on Sunday, July 8, 1934.

Officers, Councilors and committeemen present were: President, Dr. Cummer; President-Elect, Dr. Caldwell; Ex-President, Dr. Platter; Treasurer, Dr. Beer; Councilors, Drs. Huston, Klotz, Hein, Paryzek, Davidson, Shanley, Brush, Seiler and Goodman; Dr. Stone, chairman, and Dr. Upham, member, Policy Committee; Dr. Rogers, chairman, Publication Committee; Dr. Southard, State Director of Health; Dr. Bigelow, former president and general chairman of the local subcommittees on arrangements for the next Annual Meeting; Dr. Means and Dr. Sherburne, chairmen of local sub-committees on arrangemnts; Executive Secretary Martin and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on May 13, 1934 (pages 378 to 382, inclusive, of the June, 1934, issue of *The Journal*), were read, and on *motion* by Dr. Brush, seconded by Dr. Huston and *carried*, were *approved*.

1934 ANNUAL MEETING PLANS

Dr. Paryzek, chairman of the Council Program Committee, reported in detail on the scientific program for the General and Section Sessions, for the Annual Meeting of the Ohio State Medical Association, Columbus, Thursday, Friday and Saturday, October 4, 5 and 6.

On *motion* by Dr. Caldwell, seconded by Dr. Davidson and *carried*, the Council approved the detailed program as official for publication in *The Journal* prior to the meeting.

A question was raised by Dr. Paryzek concerning the use of a trade name in the title and body of a paper submitted for one of the Sections. On *motion* by Dr. Goodman, seconded by Dr. Klotz and *carried*, the Council instructed that the specific trade name should be deleted from the title and the paper if it is to be accepted by the Program Committee and presented at the Annual Meeting. In connection with a question of separating the obstetrical and pediatric papers between the two sessions of that Section, Dr. Goodman suggested to the Program Committee that the papers in each specialty be mixed in each session for the purpose of increasing interest and attendance.

Dr. Bigelow, general chairman of the local committees on arrangements for the Annual Meeting, reported on the organization of local committees, the issuance of memoranda showing the functions and duties of each committee, and the assignment of meeting places. It was agreed that whatever details of reception, dance or other function would follow the General Session on Thursday evening of the Annual Meeting, when the annual addresses of the President and President-Elect are presented, should be worked out between the Council Program Committe and the local Committee on Entertainment, and that such incidentals should be at the expense of the State Association, including music.

Further suggestions were made for the selection of a speaker on a subject of general public interest at the banquet to be held on Friday evening of the Annual Meeting, it being understood that the committees of the Columbus Academy of Medicine would assume all responsibility for the banquet with the exception that the State Association, through the Program Committee of Council, would provide an outstanding speaker on social, governmental or economic questions.

The President read a communication he had received from Dr. F. C. Haney, Columbus, president of the Ohio State Medical Golfers' Association, suggesting that a cup or trophy be presented to be known as the Ohio State Medical Journal Trophy, to be played for by the younger members (under 35 years of age) at the next tournament to be held on Wednesday, October 3, at the Columbus Country Club, the day preceding the opening of the annual session of the Ohio State Medical Association. On *motion* by Dr. Klotz, seconded by Dr. Platter and *carried*, the Council approved this request and authorized Dr. Hein, chairman of the Auditing and Appropriations Committee, to act for the Council in providing a cup or an appropriate trophy.

REPORT ON A. M. A. MEETING

Dr. Stone, the general chairman of the local committees for the annual meeting of the American Medical Association in Cleveland, reported in detail, including the financial expenditures. His report was supplemented by Dr. Upham, chairman of the Board of Trustees of the A.M.A., Dr. Brush, Dr. Cummer and others.

On *motion by* Dr. Beer, seconded by Dr. Davidson and *carried*, the Council expressed official approval to the Cleveland Academy of Medicine and its local committees for the splendid success, interest and attendance at the Cleveland meeting, and its thanks for the services of the Cleveland

members in making and carrying through the arrangements.

In connection with the report on the meeting, special attention was called and reference made to official proceedings of the House of Delegates of the American Medical Association, pages 2109 to 2120 of the June 23 issue of the *Journal A. M. A.*, and pages 2191 to 2209 of the June 30 *Journal A. M. A.*

Reference was also made to the article in the July 1 issue of the *Ohio State Medical Journal*, pages 444 to 447, inclusive, relative to the prominence of Ohio's participation in the A. M. A. meeting.

Attention was also called to the action of the House of Delegates on problems of professional relations, ethics, group and institutional advertising, in accordance with the action requested by the Council of the Ohio State Medical Association preceding the A. M. A. meeting.

Other developments of general interest, including the pending proposal for "Mutual Health Service" in Michigan, were likewise discussed with special reference to the action by the Board of Trustees and the House of Delegates of the A. M. A.

MEDICAL FACTORS IN FERA

Dr. Stone, chairman of the Policy Committee, reported in detail on a conference held in Washington, D. C., on June 26 with Mr. Aubrey Williams, first assistant to Harry L. Hopkins, federal emergency relief administrator, at which time he, Dr. Cummer, the President, and Executive Secretary Martin presented to Mr. Williams recommendations for the appointment of a full-time medical director to the Federal Emergency Relief Administration in Washington for the purpose of coordinating medical relief plans throughout the country, and in order that the medical profession might be properly represented in the administration of relief.

The delegation also requested that state relief commissions be instructed to encourage the formation of medical advisory committees in the state and in each local community where federal-state relief funds are being administered, that problems of the medical profession could be directly and effectively presented to the relief administration and in order to eliminate misunderstandings and difficulties.

Inquiry was made on the plan adopted by the Ohio Relief Commission of appropriating a maximum of $1.00 per month per family on relief for medical care and the plan of encumbering funds and pro rating of bills (as explained in the article in the July 1 issue of the *Ohio State Medical Journal*, page 448 to 450). The representatives of the State Medical Association were informed by Mr. Williams that the per family per month and the pro rating plan were not federal regulations but had been adopted by the Ohio Relief Commission. Mr. Williams promised to make efforts to promote conferences for the purpose of eliminating misunderstanding and to secure greater cooperation.

Mr. Williams also explained plans of the federal administration for legislation on "social security" including an extensive program of social insurance. He pointed out that there are 4,500,000 families on direct relief in this country at this time and that *social insurance* provisions would be extended to the 29,000,000 families in the nation under such a program.

Supplementing his report on the conference in Washington and other public developments affecting medical practice, Dr. Stone read a pronouncement containing suggestions for action.

On *motion* by Dr. Goodman, seconded by Dr. Paryzek and *carried*, this statement and pronouncement was approved by the Council and ordered published in the forthcoming August issue of the *Ohio State Medical Journal.*

This pronouncement is published elsewhere in this issue and by this reference is made a part of these minutes.

WORKMEN'S COMPENSATION DEVELOPMENTS

Dr. Hein, chairman of the Special Committee on Workmen's Compensation of the Ohio State Medical Association, reported in detail on a series of conferences and considerable correspondence with the Governor's Investigating Committee on Workmen's Compensation, interested members and other groups concerned with the problem of improving administrative procedure and efficiency at the Industrial Commission. He called attention particularly to the report and recommendations submitted to the Governor's committee from the Ohio State Medical Association on April 9 (published in detail on pages 318 to 320 of the May, 1934, issue of *The Journal*).

There was submitted for the information and consideration of the Council a detailed tentative plan considered by Dr. Hein's committee for submission to the Governor's committee on the formation and function of regional medical boards of review. There was also submitted for discussion proposed general recommendations for improvement in administrative set-up at the Industrial Commission and for better coordination and greater cooperation between the Commission, its Medical Department, Claims Department and Legal Department.

On invitation, Mr. S. P. Bush, chairman of the Governor's Investigating Committee, was present. He analyzed problems encountered and information assembled by his committee; progress to date in securing legislation for the transfer of the administrative personnel in workmen's compensation from the State Department of Industrial Relations to the Industrial Commission itself; the appointment of a personnel administrator as secretary to the Commission; the crea-

tion of enforcement and inspection departments, and a supplementary appropriation of $125,000 for the remainder of 1934 to establish greater efficiency in administration.

Mr. Bush emphasized the fundamental importance of medical care and medical administration in workmen's compensation. He stated the importance of medical organization in formulating recommendations for improvement and assured the Council of the desire of his committee to cooperate in these matters. He pointed out the importance of improvement in the system of rehabilitating injured workmen which might be a function under the direction of the proposed regional medical boards of review.

Mr. Bush also discussed several proposed statutory changes in the Workmen's Compensation Law, particularly those having for their purpose more intimate contact by employers and employes with the operation of the Workmen's Compensation Law, and through which they could maintain constant and active interest in the administration by the Industrial Commission.

On *motion* by Dr. Goodman, seconded by Dr. Klotz and *carried*, the Council expressed appreciation to Mr. Bush and pledged cooperation with his committee.

On *motion* by Dr. Paryzek, seconded by Dr. Platter and *carried*, the Council approved the substance of Dr. Hein's report and authorized his committee to proceed further in its deliberations with and recommendations to the Governor's committee.

LOCAL SCIENTIFIC PROGRAMS

Pursuant to the authorization by the Council at its last meeting, Dr. Cummer, the president, reported progress on the plan to formulate suggested study outlines for consideration by the program committees of county medical societies to increase the participation of local members in scientific programs. He submitted the first two of a series in such study outlines.

This development is referred to in the President's Page and the first of the suggested study outlines, which are both published in this issue.

PUBLICITY ON PRENATAL CARE

As authorized by the Council at its last meeting, a report was submitted by Dr. Southard, State Director of Health, on the cooperation by his Department with the Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical Association in the preparation of a newspaper article to be issued by the State Department of Health for release locally by the health commissioners in cooperation with the county medical societies.

On *motion* by Dr. Caldwell, seconded by Dr. Paryzek and *carried*, the proposed newspaper release presented by Dr. Southard was approved with the idea that copies should go to the presidents and secretaries of county medical societies from the State Department of Health as well as to the local health commissioners.

PROFESSIONAL PROBLEMS

At the request of the Council at its last meeting, Dr. Klotz presented a report on the procedure by the Academy of Medicine of Lima and Allen County in disciplining a member. The data submitted and the previous correspondence on the matter were, upon *motion* by Dr. Klotz, seconded by Dr. Paryzek and *carried*, referred to the Judicial Committee of Council for consideration and report.

A communication was submitted from Dr. Clement D. Smith, president of the Montgomery County Medical Society, to Dr. Cummer, president of the Ohio State Medical Association, relative to censure by that society of several of its members, with special reference to a member of a committee of the State Association. The communication was supplemented by a report by Dr. Platter, chairman of the Judicial Committee. President Cummer ruled that in the absence of official action to the contrary by the Council, that the action by the Montgomery County Medical Society would not change the membership status of the member in question, in as far as his relationship to the State Association was concerned, and in the absence of an appeal to the Council from the action of that society. On *motion* by Dr. Huston, seconded by Dr. Platter and *carried*, the President's ruling was sustained.

A report was submitted by Dr. Platter on a complaint by a Cleveland citizen against a member in that city, based on an allegation of unprofessional practice. On *motion* by Dr. Platter, seconded by Dr. Beer and *carried*, the correspondence on this matter was referred to the chairman of the Board of Censors of the Cleveland Academy of Medicine for information and report.

LEGISLATION AND POLICY

Dr. Stone, chairman of the Policy Committee, reported on the legislative situation and prospects, with special reference to the suggestions contained in the recent legislative bulletin of June 27. He emphasized the vital importance at this time of activity and cooperation of chairmen of legislative committees of the county medical societies and academies of medicine as recommended and urged by the Policy Committee. He also emphasized the importance of activity by the Council in contact with the legislative committeemen and the county medical societies.

Prospects for the introduction of much legislation directly affecting public health and medical practice in the next session of the Ohio General Assembly were referred to by Dr. Stone, who analyzed some of these prospective measures as referred to in recent legislative bulletins.

Dr. Cummer reported on developments on the

increase in suits and threats of suits for alleged malpractice and on the prospects of a survey by the Bureau of Medical Economics of the American Medical Association and a study and comparison of various types of indemnity malpractice insurance policies, including an inquiry and investigation of the attitude of and service rendered by insurance companies, as well as a statistical study of financial status and responsibility of such companies. He announced that a further report would be submitted at a subsequent meeting from the Bureau of Medical Economics and from the Medical Defense Committee of the State Association.

A communication was read from Dr. F. H. McMechan, editor-secretary general of the Congress of Anesthetists, under date of June 23. On *motion* by Dr. Paryzek, seconded by Dr. Beer and *carried*, the Council received this communication and ordered it placed on file.

There was submitted for the information of the Council recent correspondence with the Professional Problems Committee of the Ohio Hospital Association with plans for proposed conferences with the Policy Committee of the Ohio State Medical Association. This included reference to the outline on hospital problems and problems of professional relations presented at the last Council meeting by the President.

A report on membership statistics showed 5,119 members to date in the State Association for 1934, compared with 4,857 on the same date last year and with the total for last year of 5,187.

Dr. Stone reported on correspondence with the Code Authority for Periodic Publishing and Printing Industry, interpreting NRA provisions in relation to publications as they are construed to apply to the *Ohio State Medical Journal*. Dr. Stone submitted the report which had been made to the Code Authority.

There being no further business submitted, the Council adjourned to meet at the call of the President.

Signed:

JAMES A. BEER, M.D.,
Secretary of Council.

— OSMJ —

Ohio physicians who took part in the Seventh Annual Meeting of the American Association of School Physicians, held June 25-27, at Saratoga Springs, New York, were: Dr. A. O. DeWeese, director of the Department of Health and Physical Education, Kent State College, president of the association during the past year; Dr. Lee H. Ferguson, Cleveland, director of health service, Western Reserve University, and Dr. L. W. Childs, Cleveland, supervisor of health service, Cleveland Board of Education.

Guard Narcotics

Watch your narcotics!

This is the warning that has been sent out to physicians and druggists by the Federal Bureau of Narcotics following numerous reports of petty thievery in narcotics from all parts of the country.

Physicians and druggists are being urged to keep all narcotics under lock and key.

— OSMJ —

President Winfred G. Leutner, Western Reserve University, has announced the acceptance by the university of grants totaling $8,500 annually for two years to the School of Medicine for extension work in experimental pathology. Nathan G. and Charles L. Richman contributed $3,000; Richard H. Kohn, $500, and Nathan L. Dauby and Morton J. May, trustees of a trust fund created by Louis D. Beaumont, contributed $5,000. The money will be used to further the work of Dr. Harry Goldblatt, associate professor of pathology, and his associates in the study of high blood pressure and peritonitis.

— OSMJ —

County commissioners have no authority to contribute to the expenses of boarding a psychopathic child outside the territorial limits of Ohio even though such child is in indigent circumstances, Attorney General John W. Bricker ruled in a recent opinion concerning whether or not the commissioners of a Northeastern county can legally pay the expenses of a ward of the county now being cared for in an industrial school in New York State.

— OSMJ —

The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, has been presented by the National Society for the Prevention of Blindness, Inc., to Dr. F. de Lapersonne, French ophthalmologist and president of the International Association for the Prevention of Blindness.

— OSMJ —

The Pennsylvania State Department of Health and State Department of Education have worked out a new growth chart to supplant the method of rating a child as malnourished by its lack of pounds. The new chart bases judgment of physical condition on a child's growth in relation to its nationality, stature and type.

— OSMJ —

—New interns at St. Mary's Hospital, Cincinnati, are; Dr. Alois H. Willke, Dr. George W. Speed, Dr. Howard J. Ohl and Dr. Edwin B. Weinstein, all of the College of Medicine, University of Cincinnati, and Dr. Tomothy Wee, Northwestern University Medical School.

What will be the Status of the Medical Profession in the Changing Social Order?

This statement and pronouncement by the Policy Committee approved by the Council of the Ohio State Medical Association on July 8, is published with the urgent request for interest and activity on the part of the membership as suggested.

REVIEWING major developments in our national life in recent months, are we not led to wonder at what we formerly considered the traditional reasons for the annual observance of our recent Liberty Day?

Confronted as we are by new and rapidly changing social concepts, we find ourselves in the midst of a social revolution. As pointed out by David Lawrence in a recent issue of the *Saturday Evening Post*, our conception of independence, liberty and democracy finds itself confused by a "topsy-turvy constitutionalism" which means that the federal government is no longer the agent of the people, but that it has become the master of the people; that the states are no longer sovereign entities with exclusive power; that they have become the servants of their federal masters, and that a self-styled group of so-called liberals, otherwise known as "young intellectuals" with a passion for social experiment and a singular capacity for adroitness in the use of words and phrases, guide, direct, persuade and influence the making of laws that set up barriers between the people and the rights they once enjoyed.

To further quote from the *Saturday Evening Post:* "There are two forces contending for power, the speculative and non-productive finance capital, on the one side, and the Marxian school of politicians on the other. Both are out for monopoly, the first to retain it for the pyramiding of profits for the sake of profits, the second to capture it under the pretense of bestowing a regimented paradise on earth of which they would be the guardian angels."

Previously we had been taught to believe that democracy has for its aim the pursuit of hapiness and the fullest measure of freedom consistent with an orderly organized society.

Now we are told that we must choose betwen recovery and reform. However, reform is already here through rigid regulations of finance, credits and unrestricted profits.

As an attack on the depression we were told that new temporary and emergency measures were necessary. As a duty of patriotism we were told that far-reaching measures and regulations were imperative and that acquiescence was expected.

More recently we are told that those departures in our national life and principles of government which were expected to be merely *temporary and emergency* are to become part of a new social structure, and that in the next session of Congress the agencies of government are to be used in the establishment of means to provide protection against the vicissitudes of modern life —"In other words, social insurance", including provision for medical care.

We have, of course, realized that it is the duty of organized society to insure the necessities of life to those who cannot provide them for themselves. Such necesities, naturally, include medical service. However, in the new social program the government would depart on vast expenditures heretofore unanticipated, which would mean a new system of government financing. Various estimates which have been published of the appropriations and contingent obligations of the federal government in the period covered by the past two sessions of Congress, run into the billions. One statement containing an estimate placed the maximum figures as high as $28,000,000,000.

Serious students of government inform us that democracy cannot be maintained if the number of public employes and recipients of direct benefits from government continue in such unbalanced ratio to private endeavor, as at the present time, with approximately 4,500,000 families in this country on direct relief. In other words, the maintenance of government as proposed cannot be met by any ordinary or proved method of taxation. The alternative apparently will be a horizontal leveling-off process either destructive of or damaging to our democratic principles of private ownership of property. This leads us to a consideration of the proper function of government. Government cannot create wealth; it only utilizes and destroys wealth.

If examples in foreign countries are to be taken to heart, we find that where there has been a social demand for *security* in exchange for individual opportunity, the government collapses of its own weight and the horizontal level of the entire social structure is lowered.

We are told that timid people who fear progress apply such terms as "regimentation, socialism, communism or fascism" to what is taking place in our governmental program.

If it is timid to raise questions and to be con-

cerned about the implications and inevitable end-results through governmental socialization of property, private endeavor and professional service, then more people should become timid.

Is there any proof that social democracy is obsolete or a failure in this country? Is there any convincing reason why the structure of government based on the American Constitution should be abandoned for an idealistic, theoretical, social theory?

Through a gradual shifting to the "left", public sentiment, in its temporary but unthinking desire for broad changes in the relationship between government and citizenship, has deadened if not destroyed the impetus of private industrial and business endeavor which must be the basis of any sound and permanent system of recovery.

Just as business, industry, transportation, finance and other groups have been regimented under slogans and symbols, so is the medical profession being coerced and regimented under the new social order. The present status in government cannot be maintained. There must either be a return to constitutional democracy accompanied by proper and rigid safeguards to avoid the error and collapse of the recent era of "expansion", or there must be a further shift to the "left" and a frank recognition of and acceptance by the American people of either a type of dictatorship or communism.

As to the official policies of medical organization on the principles which should be adhered to in as far as medical service in any social experiment is concerned, the House of Delegates of the American Medical Association made pronouncement at its recent meeting in Cleveland (pages 2200 and 2201, June 30, 1934, *Journal A.M.A.*) Among the principles announced were: Medical practice under the control of the medical profession with no intermediary or "third party" arrangement; absolute freedom of choice by patients of their own qualified physicians; retention of confidential relationship between patient and physician; however the cost of medical service may be distributed, the immediate cost should be borne by the patient, if able to pay at the time the service is rendered; medical service should have no connection with insurance cash benefits; in any form of medical service, all qualified physicians of the locality covered by its operation who wish to, may render service under the conditions established; systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of income.

In reference to group medical practice problems, the Council of the Ohio State Medical Association recently pointed out that from information and data at hand the Council is not convinced that *private medical practice*, when ethically and efficiently conducted, has failed to meet social, economic and medical demands of a community (April, 1934, *Ohio State Medical Journal*, page 239).

It may be predicted positively that the future trend, tendency and structure of government in this country will be determined by the next Congress.

Even those we have considered as "radicals" are beginning to question the establishment of a colossal system of bureaucracy entangling individuals and businesses in a network of laws, rules and regulations overburdensome in expense and aggravating the distress of the people.

Even such an "advanced thinker" as Glenn Frank, president of the University of Wisconsin, is quoted in a recent newspaper interview as appealing to leaders of business, industry and finance to come forward with a program that will "prevent the ruthlessness and protect the ruggedness of individualism" as an alternative to revolution.

"There is a priceless value at the heart of private initiative that we must preserve at all cost," he said. "I do not believe that the complex economic life of the United States can ever be run effectively from Washington."

Frank said governmental imposition of broad economic policy is imperative at present, but that the administration should keep clear "the distinction between the broad guidance of economic policy and the detailed regimentation of business administration."

"We should think twice before we follow the lead of Italy, Russia and Germany with their varied versions of the philosophy of the state above all," he said.

The medical profession, being the most unselfish and humanitarian, is quite as anxious as any other group to maintain a system of adequate medical service which may be available to all the people and in accordance with the sound principles already established.

In this crisis it is a patriotic duty to be politically-minded. Prior to the political party primaries on Tuesday, August 14, arrangement should be made for frank discussions by physician constituents with their candidates for the U. S. Congress and with the candidates for the State Legislature.

Neither major political party, as party issues, has announced definite adherence to or opposition to various social tendencies in government. In fact, there are conservatives and radicals in both political parties. There are men of sound judgment and experience, and there are others lacking in qualification for legislative service in both political parties.

Consideration of these and other serious public questions affecting medical service should rise above partisanship.

GIGANTIC GOVERNMENT EXPANSION THROUGH SOCIAL ISURANCE OBJECT OF CONCERTED MOVE BY POLITICAL AND WELFARE GROUPS

Present trends, proposed legislative programs and public announcements by official spokesmen of government and lay organizations indicate that the ensuing fall and winter will witness the most concerted and vigorous campaign in the history of this country for the enactment of social insurance legislation by the Federal Congress and the legislative bodies of the various states.

Included on the agenda of most, if not all, of the official and non-official agencies and groups taking the lead in the movement for an extensive social insurance system is sickness insurance.

For this reason, if no other, it is important that the medical profession be as thoroughly and accurately informed as possible as to activities already under way in behalf of a national program of social insurance; the various proposals already formulated or contemplated; and what methods and procedure are likely to be employed in the development of such plans.

To give the medical profession of Ohio a general idea of the seriousness, scope and intensity of the current social insurance campaign, the following summary of some of the more recent important developments, together with excerpts from published statements by those in official and non-official life, is presented.

* * * *

On June 8, during the closing hours of the 73rd United States Congress, President Roosevelt sent to the Congress a message in which he reviewed some of the work of that body since March, 1933, and outlined what in his opinion should be the future objectives of the federal government.

President Roosevelt said:

"Among our objectives I place the security of the men, women and children of the nation first.

"This security for the individual and for the family concerns itself primarily with three factors. People want decent homes to live in; they want to locate them where they can engage in productive work and they want some safeguard against misfortunes which cannot be wholly eliminated in this man-made world of ours. * * *

"The third factor relates to security against the hazards and vicissitudes of life. Fear and worry based on unknown danger contribute to social unrest and economic demoralization. If, as our Constitution tells us, our federal government was established among other things 'to promote the general welfare', it is our plain duty to provide for that security upon which welfare depends. Next winter we may well undertake the great task of furnishing the security of the citizen and his family through *social insurance.* * * * *The various types of social insurance are interrelated,* and I think it is difficult to attempt to solve them piecemeal. * * *

"Above all, I am convinced that social insurance should be national in scope, although the several states should meet at least a large portion of the cost of management, leaving to the federal government the responsibility of investing, maintaining and safeguarding the funds constituting the necessary insurance reserves."

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A re-emphasis and amplification of his views on the question of social insurance are found in President Roosevelt's address over a nation-wide radio hook-up on the evening of June 28 in which he reviewed the activities of his administration to date and reiterated what he had pointed out to the Congress in his message of June 8.

Reciting again the principles of "our future program", the President explained the third feature of this program as follows:

"And, finally, the third principle is to use the agencies of government to assist in the establishment of means to provide sound and adequate protection against the vicissitudes of modern life—in other words, *social insurance.*"

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On June 29, the day following his radio broadcast, President Roosevelt announced the appointment of *a special commission to study the whole question of social insurance and to prepare a legislative program for the next session of Congress.*

Quoting from an Associated Press story of that date:

"That no time might be lost in attacking the problems of social insecurity, President Roosevelt today appointed a special committee of his close advisers to prepare a legislative program for the next session of Congress.

"It is to be equipped with a large advisory committee, with authority to hold hearings and a technical board to gather and coordinate facts and statistics.

" 'The chief problem to be attacked by the new bodies,' a White House statement said, 'is the insecurity of the individual and the family which has become to be characteristic of modern industrial life, and which threatens to become steadily more intense.

" 'The committee will study the hazards of unemployment, old age and unemployability, *in-*

dustrial accidents and occupational diseases, non-industrial sickness and disability, widowhood and the economic aspects of maternity.'

"The committee consists of Secretaries Henry Morgenthau, Jr., Frances Perkins and Henry A. Wallace, Attorney General Homer S. Cummings and Harry L. Hopkins, Federal Relief Administrator."

The President's purpose is to have the measures he contemplates ready for submission to Congress in January, according to the announcement.

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Year in and year out, one of the most militant proponents of social insurance of all description is The American Association for Labor Legislation. It will be remembered that it led the fight for health insurance legislation approximately 20 years ago.

For that reason, the following editorial comment of John B. Andrews, secretary of the organization, published in the June, 1934, issue of *The American Labor Legislation Review*, is interesting and enlightening: Quoting in part from Mr. Andrews' editorial, entitled "Postponed With Promise":

"For the first time, a President of the United States speaking as a leader of the party in power has definitely committed his administration to the early adoption of a complete social insurance program. This promise to the nation is stated with vision and courage that command respect. Many who have long advocated this program will regret that the recent Congress did not act without further delay upon old age and unemployment insurance, the two steps to which the administration was already pledged.

"Failure of the Administration at Washington to pass the Wagner-Lewis bill has temporarily thrown into uncertainty and confusion the promising movement for unemployment insurance.

"Early this February this measure, prepared with the cooperation of the Secretary of Labor and with the President's encouragement, was made to displace earlier plans introduced by Senator Wagner. It was a resourceful proposal calculated to abolish completely the hoary obstacle of 'interstate competition' while hastening the adoption of local laws in fulfillment of the national platform pledge—'unemployment and old age insurance under state laws'.

"The strategic defect of the official national leadership at Washington has been failure to grapple effectively with the urgent need of setting for the states in this matter the example of prompt legislative action. * * *

"The united support of those who concern themselves especially with social welfare measures, as well as the unanimous approval of officials summoned to Washington from the various states, was from the very beginning given to this program which the Secretary of Labor publicly predicted would result in the adoption of the desired state laws within two years.

"As the weeks dragged on and the prolonged hearings on the bill were followed by a sub-committee report 'without recommendation', the press representatives at the national capitol spread the news that unemployment insurance was not to be on the 'must pass' list, that the President instead would offer a more ambitious legislative program 'after Congress adjourns'. This deferred program, it was openly stated, would embrace 'not merely unemployment insurance', but the whole range of social insurance and many other measures. The message of June 8 confirmed this.***

"Whatever broad social program the administration presents in the political campaign this fall will naturally have that measure of appeal which its social importance deserves. The President's message is full of promise. Sincere friends of social insurance will again rally in support of the Secretary of Labor and the President. But for unemployment and old age insurance the 'covenant with the people' had already been solemnly pledged. It is devoutly to be hoped that in deferring action for a program of wider scope the official national leadership will develop the strategy required to overcome increased opposition."

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In the same issue of *The American Labor Legislation Review*, there appeared an article entitled: "A Social Insurance Spree; Lundeen Bill in Congress Attracts Left Wing Support".

The article interprets the provisions of and describes the battle waged in support of a measure introduced by Congressman Lundeen, Minnesota, which would grant authority to the Secretary of Labor to establish forms of social insurance to cover unemployment, part-time work, sickness, accidents, old age and maternity, without cost to the beneficiaries who would receive not less than $10 per week.

The Lundeen Bill was not enacted. However, as pointed out in the article, it received a surprising amount of support, indicating the strength of radical groups who, as the title intimates, are on a "spree" of social insurance legislation and making vigorous attempts to force Congress into enacting a measure that would distribute doles, pensions, etc., in the amount of billions of dollars annually.

To quote in part from the article referred to:

"A cross current this year in the unemployment insurance movement—one that has been confusing to many people—is the widely publicized campaign for the social insurance bill introduced in Congress by Mr. Lundeen of Minnesota. This so-called 'workers unemployment and

social insurance bill' * * * has received considerable support, some of which has come from unexpected sources.

"In a leading article in *Social Work Today*, Dorothy W. Douglas, assistant professor of economics at Smith College, refers scornfully to 'faint-hearted reformists' who, frightened by 'specious warnings' from the opposition, 'fail to recognize the tremendous force of mass pressure in getting legislative results', and who therefore work for such 'inadequate' measures as the Wagner-Lewis bill in Congress and proposals for state unemployment insurance legislation. She urges professional workers to support 'without reservation' the 'organized effort of the working class' in behalf of the Lundeen bill, 'a straight workers' measure . . . framed by workers themselves'.

"Three persons appeared to speak for the Lundeen bill at a hearing before the House Committee on Labor on February 21. They were Herbert Benjamin, prominent Communist, who represented the National Unemployment Councils of the United States which secured the introduction of the bill; David Gordon, representing the Communist-inspired 'American Federation of Labor Trade Union Committee on Unemployment Insurance'; and Mary van Kleeck, director of industrial studies of the Russell Sage Foundation.

"The Lundeen bill's provisions are few and simple. The Secretary of Labor is directed 'to provide for the establishment of a system of unemployment and social insurance' for 'all time lost' with benefits amounting to 'average local wages' but not less than $10 weekly. These benefits are to be paid to 'workers and farmers' for unemployment caused by no fault of their own, and also for 'part-time work, sickness, old age or maternity'. Necessary funds are to be provided 'at the expense of the government and of employers', the government's share to be raised by taxing inheritances, gifts, and incomes. Administration of this plan, which its proponents estimate would have cost 21 billion dollars in the one year 1932, is through 'commissions composed of the rank and file members of workers' and farmers' organizations' under rules prescribed by the Secretary of Labor. * * *

"The brevity and apparent simplicity of the provisions of the Lundeen bill have been a great advantage to its sponsors in their drive for support. Their campaign has been centered upon 'principles' and has been unembarrassed by the necessity of working out and explaining the difficult details for putting these generalities into actual operation. The bill also had the characteristically zealous advocacy of extreme 'left wing' groups and their sympathizers. Many of its supporters, in fact, are obviously interested not directly in unemployment insurance but rather in using this issue as a device for agitation for more 'drastic social reconstruction'."

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Just for good measure, Mr. Andrews presents in the same issue of his publication an article by I. S. Falk, Ph.D., research associate of the Milbank Memorial Fund, entitled: "Formulating An American Plan of Health Insurance".

Leading off with the statement, "Neither the rich nor the poor, nor the great middle classes of the American people receive anything like adequate medical care", Mr. Falk reiterates the same arguments in favor of compulsory health insurance that he and his associates have been publicizing extensively for quite some time.

Mr. Falk presents what he believes to be the objectives of an "American Plan" and summarizes some of the questions he thinks must be clarified in the formation of such a plan. He concludes with the following statement:

"These and other questions require careful study; but neither their number or variety should discourage us. The experience of many countries proves clearly that there are no insuperable obstacles to the establishment of a sound system of health insurance. Certainly, it is not in the spirit of our time to be timorous or fearful of attacking the problem. The example which is being set by the President and by administrative and legislative groups everywhere should give us heart and a renewed determination. Indeed, those who have been called to the obligations of high places have a right to expect that all who are competent in the task will devote themselves to the careful and dispassionate formulation of a health plan for the people of the United States."

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"President Roosevelt's vision of social security through a comprehensive national program of old-age pensions, health insurance and unemployment insurance will catch the popular imagination", Charles H. Melish predicts in the July, 1934, issue of *The Forum*. (A Lesson in National Self-Respect, Page 24).

Mr. Melish glibly declares that "of course there is nothing new in the idea of national social insurance" and that "parenthetically it may be noted that health insurance and the provision of old-age pensions present no technical difficulties". His basis for that statement is:

"Insurance records reveal with reasonable accuracy how often sickness is likely to occur. We can readily determine how many attain old age with insufficient means to provide for their own support. The problem is reduced to the mathematical calculation of the amounts which must periodically be put aside to provide a reserve sufficient to meet future withdrawals."

In conclusion, the writer asserts:

"Some form of social insurance for the United

States is inevitable. If we undertake it now we shall be better able to withstand the shocks of the next depression when it strikes, as it surely must. The cost of the vast undertaking that the President apparently contemplates will naturally be tremendous. But we will get for our money nothing less than the recovery of our national self-respect."

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"Planned Social Economy and End of Profits Urged" is the heading of an article published in the July 7, 1934, issue of *The Literary Digest*, page 29, indicating, *The Digest* editorially points out, "the leftward swing of the churches" and furnishing an example of "an influential denomination gone definitely Socialist and apparently challenging the New Deal".

The article deals with the pronouncements made by the General Council of the Congregational and Christian Churches at a recent meeting in Oberlin, Ohio, and is in part as follows:

"Venturing a step further than its sister denominations, the General Council of the Congregational and Christian Churches, which met at Oberlin, Ohio, has adopted a *resolution pledging its member churches to work for the abolition of the profit system and for a planned social economy*. The profit system was condemned out of hand as being based on the exploitation of one class by another and as being destructive of all human values. To it is attributed international and industrial war, unemployment, insecurity, starvation and misery.

"The daring step at Oberlin is another indication of the leftward swing of the churches, most of which are developing an increasing antagonism toward the old social and political order and calling boldly for a decentralization of wealth and power, and a wider and more equable distribution of the means of abundance at hand.

"The Oberlin resolution does more than cry out against the old order. It is a definite pledge to work toward the abolition of the present system, and 'the inauguration of a thoroughly planned and organized social economy, which will apply all our natural and human resources directly to the meeting of human needs, in pursuit of values democratically chosen, which will

"'(a) Adjust production to measured consumption requirements, and maintain and extend social services, health, education, recreation, and insurance for all.

"'(b) Eliminate private ownership in the means of production and distribution wherever such private ownership interferes with the success of a planned social economy, making profit unnecessary and impossible.

"'(c) End unemployment, abolish poverty, enable maximum prevention of disease and crime, and stimulate the fullest development of the arts and sciences.'

"Here then, is an influential denomination gone definitely Socialist and apparently challenging even the New Deal."

— OSMJ —

A cooperative group to act in an advisory capacity with regard to control of medical specialties was formed recently in Chicago. The new board to be known as the Advisory Board on Medical Specialties will include two representatives from each of the following organizations: Council on Medical Education and Hospitals of the American Medical Association, Association of American Medical Colleges, National Board of Medical Examiners, Federation of State Medical Boards, American Hospital Association, American Board of Ophthalmology, American Board of Otolaryngology, American Board of Obstetrics and Gynecology, and American Board of Dermatology and Syphilology. Officers elected were: President, Dr. Louis B. Wilson, Rochester, Minn.; vice president, Dr. J. S. Rodman, Philadelphia, and secretary-treasurer, Dr. Paul Titus, Pittsburgh. Provision was made for representation of other examining boards in other specialties and from various sections of the American Medical Association.

— OSMJ —

—Dr. C. M. Hanson has resumed his duties as health commissioner of Mansfield and Richland County after completing nine months' work in public health administration at Yale University. Dr. J. H. Hayes, who carried on the work during Dr. Hanson's absence, plans to return to Little Rock, Ark., his former home to engage in active practice.

— OSMJ —

Toledo—Dr. John T. Murphy, president of the American Roentgen Ray Society, was elected president of the American College of Radiology at its recent meeting in Cleveland.

— OSMJ —

—The following residence and intern staffs have been announced at St. Luke's Hospital, Cleveland:

Dr. Frank R. Hill, resident in surgery, calendar year, 1934; Dr. John J. Monfort, resident in surgery, 1935; Dr. Daniel F. Toth, resident in obstetrics; Dr. Howard B. Beck, resident in ear, nose and throat; assistant residents: Dr. Lance C. Price, George Washington University, medicine; Dr. Craig G. Wales, University of Chicago, medicine; Dr. John A. Topinka, Ohio State University, second assistant in surgery; Dr. Seeley Nash Gray, George Washington University, third assistant in surgery; Dr. Harold F. Burkons, University of Michigan, obstetrics; Dr. James V. Stewart, Western Reserve, ear, nose and throat; Dr. Alex Gross, University of Louisvilie, pathology.

Internes: Dr. William A. Avery, Dr. Homer J. Daus and Dr. Thomas W. Watson, Western Reserve; Dr. John G. Feder and Dr. Thurman F. McAllister, Ohio State University; Dr. John W. Holcomb and Dr. Raymond Le Roy Shilling, University of Michigan; Dr. Frank R. Jamison and Dr. Alfred D. Miesner, Rush Medical School of the University of Chicago; Dr. George R. Benton, Jr., University of Pennsylvania; Dr. Forest M. Dunn, University of Rochester; Dr. C. W. Goodwin, University of Pennsylvania; Dr. H. D. Haines, George Washington University; Dr. Robert E. Mountain, Cornell University, and Dr. Roland P. Hahn, dental intern, Ohio State University.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

To insure vigorous life to a county medical society, nothing is so essential as its scientific programs. The main reason for its very existence is its educational objective, which differentiates it from a trades organization. Stimulating and instructive medical discussions are of inestimable value primarily as a medium for the transmission of scientific ideas, and they serve another purpose scarcely less important, for they increase attendance and keep the society keyed to a high pitch of interest, enthusiasm, and efficiency.

In recent years there has been a growing tendency to depend upon guest speakers. This is to be deplored in many ways. Once the custom has been started, it tends to perpetuate itself and no matter how greatly the attendance is stimulated at the start, due in part to the natural desire to see and hear well-heralded strangers, it gradually drops off. The next step in some of the smaller counties has been to combine the meetings of three or four counties on the theory that a speaker could reach a larger number of auditors. While this has been the case at the start, I am informed that eventually the process has had the reverse result and as one experienced secretary wrote, "The members were lulled into a condition of inactive desuetude. They have simply sat and swallowed what was given them without any attempt at masticating not to mention digesting it. Now you know that an individual who just sits and listens without putting forth any active effort develops no power although he may amass some information." As a result of placing sole reliance upon outside talent, the members lose the power of expressing themselves in the presence of their colleagues, and as the same observer wrote, "sit around with their mouths wide open like young robins waiting to be fed".

Those responsible for arranging programs are often confronted with difficulty in persuading members to participate. This may result from diffidence or from reluctance to make the necessary preparation, but the study involved in the preparation of a paper is beneficial to him who assumes the duty. One of the best ideas which I have seen for county programs came from Dr. J. F. Weitz of Montpelier, Ohio, who prepared and used successfully a series of *study outlines* while serving as secretary of the Williams County Medical Society, and to whom I am greatly indebted for constructive criticisms and pungent expressions. Formulation of such outlines requires knowledge, vision, and effort. It may be that few local secretaries or program committees would be willing to give the time and thought required. To meet this possibility a number have been prepared by volunteers, two of which are printed in this issue. Of course, their employment is optional with county societies, but it is our hope that many will give this system a thorough trial. The advantages of this plan should be apparent. The subjects touch upon important phases of medical practice in which constant advance is being made and should interest general practitioners. If preliminary study is made along the lines indicated by the outlines, and this is the *sina qua non* of the system, a member will go to the meetings prepared to understand and to take an intelligent part in the discussion, and the points brought out will become part of his own personal store of knowledge.

Other varieties of programs can be suggested. In some societies series of resumés of progress in different branches of medical practice have been arranged and presented by speakers who have followed the current literature in assigned fields and summarize the important discoveries or changes in viewpoint. These are valuable of themselves and also serve as a basis for general discussion, but they are suitable only for occasional use since inherently they are too hurried and sketchy in nature to be useful as a regular feature. Another type of program takes the form of a round-table discussion of interesting cases, each member being called on in turn to relate some unusual or interesting clinical experience. The main objective is to secure participation of as many members as possible and a general interchange of ideas. This has proved very successful in smaller and more intimate groups, provided the speakers condense their remarks and present only the essential clinical features.

It would be a mistake for any society not to invite occasional guest speakers. They lend the variety which is the spice of life and bring in new ideas. Probably, the best solution of the program problem is a combination of local and out-of-town speakers, with a predominance of the former. It is suggested that where several counties have merged as 3 or 4 county societies, they split up and meet independently as county societies at least five or six times yearly to listen to local speakers, using the study outline or round-table system, and that they then meet two or three times yearly as a combined society to listen to guest speakers. This would solve important problems of program by maintaining local organizations. When guest speakers appear, usually courtesy demands that their papers be discussed freely, and such discussion should be arranged in advance if necessary, even

though it takes only the form of well-directed questions. The essayist desires to get the reaction of the audience to his ideas and hopes to hear pertinent questions so that he may amplify the development of his subject in his closing remarks.

County secretaries should beware of giving places on the programs to those writing in their own behalf and asking, or possibly even demanding, an opportunity to appear. Few desirable speakers are obliged to solicit "stump-speaking" engagements; those doing worthwhile scientific work are sought for and they rarely have to seek engagements. In case of doubt as to the suitability of a self-nominated speaker, advice should be sought from the district councilor or our headquarters office in Columbus.

In the order of business for meetings of the county societies, time should be planned for the reports of the Legislative and Economic Committees. In these days of continued social upheaval, it is desirable that such matters be considered at every meeting. Many articles and editorial comments on these subjects appearing in our *Journal* can be reviewed and discussed profitably. Advice given in the special bulletins issued by the Policy Committee of the State Association frequently should be passed on to the membership at large by the local Legislative Committeeman. At least one meeting in each year should be devoted entirely to the discussion of social and economic questions, a wise provision in the By-Laws of the State Association which, I fear, is honored more in the breach than in the observance.

The approach of the autumn months should make all members think of resuming work in their county societies and it is our hope that serious attention will be given to the planning of stimulating and instructive programs on a far-seeing basis, remembering the need of giving all members a chance to participate in what should be a course of instruction, to the end that we may be better fitted to care for those who look to us for medical service.

"STUDY OUTLINES" ON SCIENTIFIC SUBJECTS FORMULATED TO ASSIST IN STIMULATING INTEREST IN COUNTY SOCIETY PROGRAMS

To assist in a concrete way the officers and program committees of the component county medical societies or academies of medicine of the State Association in formulating programs for meetings that will tend to stimulate local interest and attendance, afford an opportunity for more members to participate in each program, and assure timely and thorough discussion of a greater number of medical and public health questions of general importance, a series of "study outlines" on scientific subjects of general interest has been prepared at the request and under the direction of the President, Dr. C. L. Cummer, Cleveland, for use by as many county societies or academies as care to do so in preparing programs for forthcoming meetings.

The first two "study outlines" of this series are presented this month by *The Journal*, one on "Scarlet Fever", by Dr. J. F. Weitz, Montpelier, and one on "Peritonitis", by Dr. Carl H. Lenhart, Cleveland. Others will be published in subsequent issues of *The Journal*.

As pointed out in the President's Page comments in this issue, the employment of the "study outline" plan for county society programs is entirely optional with the respective societies. The plan is merely suggestive. It is offered solely to assist local program committees and as a possible stimulant for county society meetings.

It is Dr. Cummer's belief that county societies wishing to try out the plan may find the "study outlines" published in *The Journal* helpful in inaugurating the idea but that eventually the program committee of the respective county societies would formulate, or have formulated by members of the society, "study outlines" on additional subjects in case it is decided to continue using the plan.

Following is a brief summary of the operation of the plan:

The first step involves a selection by the program committee of the subjects around which the programs can be built. Subjects of general interest and importance should be chosen.

After the program subjects have been decided upon, "study outlines" on each subject should be prepared, either by the program committee or members of the society sufficiently informed on the subject to enable them to assemble a comprehensive outline. The outlines published in *The Journal* are available for use by any society caring to do so.

The preparation of papers dealing with the different phases of the subject, as suggested by the "study outline", should be assigned to members.

Well in advance of each meeting, a copy of the "study outline" for the subject to be discussed at the meeting should be sent to each member of the society with a request that he use it in a pre-

liminary study of the subject and come to the meeting prepared to take part in the discussion scheduled to follow the presentation of the formal papers.

In the copy of the program sent to members of the society preceding each meeting, the names of the essayist and discussants for each paper should be inserted opposite the title of the paper.

As Dr. Cummer emphasizes in his President's Page:

"If preliminary study is made along the lines indicated by the outline, and this is the *sina qua non* of the system, a member will go to the meeting prepared to understand and to take an intelligent part in the discussion and the points brought out will become part of his own personal store of knowledge."

Study Outline No. 1

Scarlet Fever

By J. F. WEITZ, M.D.
MONTPELIER, OHIO

OUTLINE FOR STUDY

1. Symptoms.
   - A. Malaise.
   - B. Headache.
   - C. Vomiting.
   - D. Angina.
   - E. Fever.
   - F. Strawberry tongue.
   - G. Eruption.
   - H. Desquamation.
2. Types.
   - A. Ordinary.
   - B. Mild.
   - C. Severe.
   - D. Toxic or malignant (cerebral).
   - E. Heterologous scarlet fever (variation in toxin (1).
3. Diagnosis.
   - A. History of exposure and development.
   - B. Symptoms.
   - C. Eruption on soft palate.
   - D. Leede's Sign (petechia from artificial stasis.
   - E. Pastia's Sign.
   - F. Leucocytosis (quite common, not specific).
4. Etiology.
   - A. Immediate (infection).
   - B. Predisposing.
     1. Age 3 to 8 most susceptible.
     2. Natural susceptibility vs. natural immunity. Dick test for artificial immunity. Dilute toxin or toxoid by (a) hypo; (b) inunction (2) (3). Permanence of (4).
5. Transmission.
   - A. Direct.
   - B. Indirect.
6. Period of incubation.
7. Period of invasion.
8. Period of infection.
9. Complications and Sequelae.
   - A. Angina.
   - B. Otorhinologic (5).
   - C. Adenitis and cellulitis.
   - D. Nephritis.
   - E. Cardiac lesions.
   - F. Joint lesions.
10. Prophylaxis.
    - A. Isolation of patient and nurse.
    - B. Concurrent disinfection.
    - C. Terminal cleansing (or fumigation).
    - D. Immunization of susceptible contacts.
11. Treatment.
    - A. General management of patient.
      1. Rest in bed.
      2. Diet.
      3. Bathing and inunction.
    - B. Medicinal.
    - C. Serotherapy.
      1. Antitoxin (6).
      2. Immunotransfusion (7).
      3. Convalescent serum (8).

PAPERS

1. General consideration of the disease.
2. Nose, throat and ear sequelae.
3. Nephritis and cardiac lesions.
4. Instruction in prophylaxis. (Health commissioner).

General discussion.

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4. *Bull* (H. G.) Report on a group of fifty children Dick-tested eight years after immunization against scarlet fever. Jour. A. M. A. 363, *101*, 1933 (July 29).
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8. *Rhoads* (P. S.) and *Gasul* (P. M.) Con-

valescent scarlet fever serum and commercial antitoxin. A comparison of their protective values. Jour. A. M. A. 2005-2008, *102*, 1934 (June 16).

Study Outline No. 2

Peritonitis

By CARL H. LENHART, M.D.
CLEVELAND, OHIO

OUTLINE FOR STUDY

1. The resistance of peritoneum to infection.
   - A. Experimentally.
     1. Difficult to produce by inoculation of pure cultures even in enormous dosages.
     2. Mixed cultures more successful.
     3. Presence of foreign body (potato) fecal matter or gangrenous tissue most successful.
   - B. Clinically.
     Survey importance of *perforation* of gut *gangrenous* tissue as etiological factors. *Review* instances of acute infections of abdominal organs not leading to more than very local peritonitis, unless perforation and/or gangrene present. *Review* comparative frequency of various diseases as cause of peritonitis. *Explain* puerperal sepsis as a cause without either factor of perforation or gangrene. *Explain* rarity of gallbladder disease as a cause.
   - C. Analysis of protective mechanisms (rarity of septicemia).
     1. Resorptive power.
     2. Bactericidal power.
     3. Localizing power.
2. Importance of *early* diagnosis and prophylactic operation in diseases characterized by perforation of gut and/or gangrene.
   - A. Use appendicitis statistics to show:
     1. Effect of delay in operation on: (a) mortality rate; (b) incidence of general peritonitis; (c) mortality rate, even when peritonitis is already present; (d) incidence of perforation.
   - B. Show that perforation and gangrene frequently occur early and before a positive diagnosis can be made.
   - C. Emphasis on conclusion that a reasonable degree of error in early diagnosis is legitimate; that too great striving for accuracy is dangerous for the patient.
   - D. What is a fair diagnostic "batting average" if we are to avoid the catastrophes due to late or no operation?
3. Diagnosis of appendicitis.
   - A. Direct diagnosis.
     1. Enumerate important symptoms and signs.
     2. Evaluate their relative importance.
     3. Estimate the percentage of frequency of typical cases.
     4. As a guide to decision to operate, what would you consider the minimum evidence?
   - B. Other diseases which demand differentiation from appendicitis.
     1. General diseases.
     2. Circulatory and respiratory.
     3. Abdominal.
     4. Urinary.
     5. Genital.
     6. Spine and nervous system.
   - C. Where symptoms are more or less equivocal, one has to fall back on probabilities. Discuss, statistically if possible, the frequency with which diseases under "B" appear to confuse us in the correct diagnosis of appendicitis.
4. The operative treatment of existent peritonitis.
   - A. Diffuse open—free or so-called general peritonitis (limit discussion to appendix peritonitis).
     1. Time to operate.
     2. Operative removal of exudate.
     3. Drainage question.
   - B. Circumscribing, circumscribed localized peritonitis (limit to appendicitis in the main).
     1. Time to operate. Why?
     2. Operative removal of appendix.
     3. Drainage.
     4. Factors to consider in above decisions: (a) spontaneous rupture of abscess; (b) leaks, with secondary abscess; (c) pylephlebitis; (d) toxemia; (e) thrombosis—embolism; (f) ileus, fecal fistula, wound infection, hernia; (g) influence on time of hospitalization; (h) subsequent attack if appendix not removed; (i) general peritonitis even after drainage; (j) difficulty of operation at various stages.
5. The pathologic physiology of peritonitis.
   - A. The peristaltic and pendular movements of gut and the influence of peritonitis on these movements both by direct effect and by mechanical (adhesions) action.
   - B. The influence of peritonitis on the circulation of the blood.
   - C. The pathologic physiology of ileus.
     1. Kinds—mechanical and functional.
     2. Dilatation stomach and bowel.
     3. Strangulation, gangrene, perforation.

4. Intoxication theories, including bacterial.
5. Water and salt loss theory.

6. General therapy of peritonitis and non-mechanical ileus.
   A. Rest—mental, physical, comfort, etc. How best given?
   B. Nothing into gastro-intestinal tract.
   C. Emptying afferent loops and stomach.
      1. Stomach and duodenal tubage: (a) Intermittent; (b) continuous; (c) continuous with suction.
      2. Enterostomy.
   D. Restoration of fecal flow.
      1. Not important early in ordinary functional ileus.
      2. Cathartics.
      3. Enemas.
      4. Peristaltic hormones.
      5. Spinal anesthesia.
   E. Water, salt, glucose injections—rectal—subcutaneous—intravenous.
   F. Question of blood transfusion.
   G. Sera and vaccines.
   H. What symptoms to watch as guide to therapy and prognosis.

7. Therapy of border-line mechanical ileus.
   A. Enterostomy.
   B. Better drainage.

8. Real mechanical ileus.
   A. Therapy.
      1. Enterostomy. When? How?
      2. Entero-anastomosis. When? How?
      3. Complications.
      4. Release of adhesions.
      5. Excision of sections of gut.
   B. Frequency and late appearance in peritonitis.
   C. Its diagnosis including ausculations and *X*-ray.

9. Vital importance of an old subject.
   A. Statistical proof of frequency of this disease.
   B. Frequency of deaths.
   C. Compare with possible more interesting but rarer conditions.
   D. Secular increases?
   E. Educational campaigns for laity and physicians.

PAPERS

1. The diagnosis of appendicitis.

2. The indications as to time for and major procedure in operating for peritonitis following those diseases of frequent etiological significance (especially appendicitis).

3. The pathology and therapy of functional ileus.

Comments on Medical Expert Witnesses

The article published on page 464 of the July, 1934, issue of *The Ohio State Medical Journal* quoting excerpts from an address on medical expert testimony delivered by Judge Benton S. Oppenheimer, Cincinnati, before the Cincinnati Academy of Medicine, has caused considerable discussion among members of the medical profession.

Some physicians have expressed themselves as believing Judge Oppenheimer overlooked the underlying causes for the suspicion which he thinks the public has regarding the medical expert and that, therefore, he was unduly critical of the medical profession with respect to abuses that have arisen in the use of physicians as expert witnesses.

The following comment was received from a physician with reference to the article and, in effect, expresses the viewpoints of other members of the profession who have declared themselves as differing with Judge Oppenheimer's conclusions. To quote:

"Judge Oppenheimer, in giving to physicians advice concerning expert testimony (*Ohio State Medical Journal*, 30:464, July, 1934), seems to have overlooked the primary cause of the prevailing distrust of such testimony. Consequently, the treatment he suggests is only palliative. Such treatment will not remove the cause of the difficulty, and until the cause is removed, the difficulty will continue.

"No expert witness goes on the witness stand unless he is put there by a lawyer or by the court. No expert witness goes on the witness stand unless his qualifications have received the approval of the court. Lawyers and courts have ample time to learn the qualifications of prospective expert witnesses before putting them on the witness stand. It is their duty to do so. If expert testimony has been and is discredited by incompetent, biased, or venal expert witnesses, the fault lies primarily with the lawyers who produce them as witnesses and with the courts that tolerate them.

"So long as lawyers purchase incompetence, bias, and venality—and those traits will always be on the market in every walk of life—and so long as courts allow themselves to have incompetence, bias and venality thrust upon them, so long will the present unhappy state of expert testimony continue. Th remedy lies in the hands of the bar and the bench."

— OSMJ —

—Dr. Charles Adkins has been succeeded as house physician at Ft. Hamilton Hospital, Hamilton, by Dr. William E. Callison, formerly an intern at Cincinnati General Hospital. Dr. Adkins has opened offices at Coldwater.

HOTEL RESERVATIONS SHOULD BE MADE NOW FOR THE ANNUAL MEETING, OCT. 4, 5 AND 6

Hotel reservations should be made in the near future by members of the Ohio State Medical Association who are planning to attend the 88th Annual Meeting at the Neil House, Columbus, on Thursday, Friday and Saturday, October 4, 5 and 6, and the annual tournament of the golfers' association on Wednesday, October 3.

Columbus is liberally supplied with hotels offering splendid accommodations. However, it is a busy convention city and to assure themselves of obtaining the type of rooms they desire, members of the State Association are advised to write for reservations immediately.

Requests for reservations should be sent direct to the management of the hotel selected and verification of the reservation should be obtained.

The headquarters hotel will be the Neil House which will house the entire Annual Meeting.

Following is a list of Columbus hotels, their rates and conveniences:

NEIL HOUSE

Headquarters Hotel

High Street Opposite State Capitol

655 rooms, all with bath; single room, $2.50 to $5.00; double room, $4.50 to $7.00; double room, twin beds, $5.00 to $7.00; suites, $7.00 up.

DESHLER-WALLICK

Broad and High Streets

1000 rooms, with bath; single room, $2.50 to $7.00; double room, $5.00 to $12.00; double room, twin beds, $6.00 to $12.00; suites, $10.00 to $25.00.

FORT HAYES

33 West Spring Street

300 rooms, with bath; single room, $2.00 to $3.00; double room, $3.50 to $5.00.

CHITTENDEN

Spring and High Streets

275 rooms; single room, with bath, $1.75 to $3.00; single room, without bath, $1.50 to $1.75; double room, with bath, $3.00 to $4.00; double room, without bath, $2.25 to $3.00; double room, twin beds and bath, $4.50 to $5.00; double room, twin beds but without bath, $3.50.

SOUTHERN

Main and High Streets

230 rooms; single room, with bath, $2.00 to $3.00; single room, without bath, $1.50 to $2.00; charge of $1.00 for each extra person and $1.00 additional for rooms with twin beds.

NEW VIRGINIA

Third and Gay Streets

130 rooms; single room, with bath, $1.50 to $2.50; double room, with bath, $2.50 to $3.50; single room, without bath, $1.25 to $1.50; double room, without bath, $2.00 to $2.50.

COLUMBUS

Long and Fifth Streets

200 rooms; single room, with bath, $1.50; double room, with bath, $2.50; single room, without bath, $1.00; double room, without bath, $1.75.

JEFFERSON

17 East Spring Street

80 rooms; single room, with bath, $1.75 to $2.25; single room, without bath, $1.25 to $1.50; double room, with bath, $3.00 to $4.00; double room, without bath, $2.50 to $3.00; suites, $5.00.

— OSMJ —

Ohio Officers of A. M. A. Sections

During the business sessions held by the various scientific sections at the 85th Annual Session of the American Medical Association in Cleveland, June 11-15, the following Ohio physicians were elected section officers, or delegates or alternates from their respective sections to the A.M.A. House of Delegates for the year 1935:

Section on Practice of Medicine—Dr. M. A. Blankenhorn, Cleveland, vice chairman.

Section on Surgery, General and Abdominal—Dr. Robert Scott Dinsmore, Cleveland, vice chairman.

Section on Obstetrics, Gynecology and Abdominal Surgery—Dr. A. J. Skeel, Cleveland, vice chairman.

Section on Pediatrics—Dr. A. Graeme Mitchell, Cincinnati, chairman and alternate delegate.

Section on Pharmacology and Therapeutics—Dr. Russell L. Haden, Cleveland, secretary.

Section on Dermatology and Syphilology—Dr. Clyde L. Cummer, Cleveland, delegate; Dr. James R. Driver, Cleveland, vice chairman.

Section on Preventive and Industrial Medicine and Public Health—Dr. Harry L. Rockwood, Cleveland, vice chairman.

Section on Urology—Dr. Thomas P. Shupe, Cleveland, vice chairman; Dr. Henry L. Sanford, Cleveland, alternate delegate.

Section on Radiology—Dr. Bernard Nichols, Cleveland, vice chairman; Dr. John T. Murphy, Toledo, secretary.

PROGRESS UNDER REGULATIONS FOR MONTHLY PAYMENT FOR MEDICAL RELIEF AND WORKS DIVISION ACCIDENT CASES

Figures recently compiled by the auditing department of the State Relief Commission show that from January 1, 1934, to July 1, 1934, $308,148.33 had been paid out of federal-state relief funds for medical care of the needy in the state as a whole.

The amount paid out for each of the six months was as follows: January, $16,071.55; February, $43,456.76; March, $45,689.30; April, $47,712.38; May, $56,929.56, and June, $98,288.78.

The total number of families on the relief rolls of the state during the six-months period was as follows: January, 126,953; February, 146,975; March, 167,025; April, 146,120; May, 158,444, and June, 171,688.

The $308,148.33 medical care expenditure does not include medical bills contracted but unpaid. It represents the amount actually paid out by the local relief administrations from federal-state funds for medical care in the home under Rules and Regulations No. 7 of the Federal Emergency Relief Administration. Expenditures for medical care, hospitalization, etc., from local funds and money paid out for medical care of persons injured on projects under the Works Division of the State Relief Commission are not included in these figures.

The "paid-out" figure for medical care in the home does not give an accurate picture of the total amount of medical care rendered by the physicians of the state under the State Relief Commission's medical relief program since in some communities sizeable bills for medical care authorized by the local relief administration still are unpaid.

This situation arose through the failure of relief administrations in some counties to use funds accruing to the county relief fund for medical care under the $1-per-month-per-family on relief for that purpose but for other relief activities.

The statistics showing the number of families on the relief rolls indicate that a total of $1,086,604 would have been available from federal-state funds to meet medical bills under Rules and Regulations No. 7.

The plan inaugurated by the State Relief Commission on June 1 making it mandatory that each time medical care is authorized, funds be encumbered to meet the costs of such service, it is believed, will remedy some of the difficulties that have arisen in administration of the medical care program. (See July, 1934, issue *The Journal*, page 448). It has been pointed out by relief officials that the encumbering plan will tend to prevent the diversion of medical care funds for other purposes. However, as long as the State Relief Commission continues to allot funds for medical care on the $1-per-month-per-family basis, pro-rating undoubtedly will be found necessary in some counties and during periods of high disease incidence. If good judgment and care are used in the administration of the medical relief program in each county, there is a possibility that pro-rating may be avoided or, at least, kept at a minimum.

For this reason, it is essential that each county medical society keep in close contact with the local relief director and keep informed on the administrative procedure in connection with the medical relief plan. Although the State Relief Commission has not as yet advised local relief administrations to formulate a local medical advisory committee in cooperation with the county medical society, as contemplated in Rules and Regulations No. 7, this has been done in some counties. There is nothing to prevent a local relief director from forming such an advisory committee in cooperation with the medical profession of the county to assist and advise him on the medical phases of local relief activities.

As pointed out in the July issue of *The Journal*, it is important that physicians submit their fee bills to their local relief director promptly. In some counties physicians are not doing this. This disrupts the bookkeeping work of the local and state relief administrations and prevents promptness in the payment of medical bills. An effort is being made to pay physicians' bills between the first and the tenth of each month for the preceding month. If, however, a physician fails to submit his bill for services in any one month by the last day of that month, he will not be paid until another month has elapsed. In addition, he will be put to the bother and time of making out new forms and encumbering blanks since all dates of visits on any one invoice used for encumbering must be within the same month.

Several county relief directors have inquired of the State Relief Commission regarding authorizing operations in the home of the patient. As specified in Rules and Rgulations No. 7, expenses of hospitalization cannot be paid out of federal-state funds but must be met by local funds. In answering such inquiries, the medical department of the commission advised that local relief directors not authorize the performance of surgical operations in the home of the patient unless

the condition of the patient is such that he can not be moved to a hospital and prompt operation is deemed vital to save his life.

As a result of several controversies that have arisen regarding the medical responsibility of the State Relief Commission in a number of injury claims filed by persons employed on projects under the Works Division, instructions have been issued by the Safety Department of the Commission to county relief directors advising careful investigation of border-line injury cases and that the *initial medical examination only* should be authorized until the Commission's responsibility in the matter has been determined.

The instructions issued to the county relief directors on this question were as follows:

"We are receiving an excessive number of IR and FB reports involving sprains, strains and hernias, many of which do not establish the fact that the conditions complained of are the result of injuries sustained in the course of employment on F.E.R.A. projects.

"The responsibility of the State Relief Commission to pay medical and hospital expenses is limited to cases in which *injuries* are received *in the course of or arise out of employment* on projcets under the Works Division of the F.E.R.A. We, therefore, can authorize the *first examination only*, in cases of other than those of definite traumatic origin, pending the determination of the Commission's responsibility in the case by the Safety Department, upon receipt of the IR and FB forms.

"When it is found, upon examination of the IR and FB forms, that the case is the medical responsibility of the State Relief Commission, authority to continue treatment will be given by the Safety Department. The medical expense of cases in which the Commission has no liability must be borne locally, as indigent cases."

In line with these instructions, physicians handling Works Project injury cases should submit IR and FB forms to the local relief director as soon as possible after the first examinations, especially in border-line cases, so that it can be determined promptly whether the State Relief Commission will bear the expense of further medical care, or whether subsequent treatments should be under Rules and Regulations No. 7 governing medical care in the home of indigents. Initial FB-1 forms under the regulations of the Safety Department must be filed within two weeks after the first medical examination.

Medical claims are being handled promptly by the Safety Department of the Commission as indicated by the following figures showing the condition of the department as of July 9, 1934:

Number of medical claims reported, 941.

Number of medical claims received by the department, 853.

Number of medical claims outstanding, 88.

Number of medical claims sent to auditing department, 655.

Total amount paid to physicians, $2660.91.

Average amount paid for each man injured, $4.06.

Number of claims ready for auditing department, 134.

Number of claims being held for investigation, 64.

Up to June 28, 1934, the total number of lost-time accidents under the Works Division program was 180. Medical cases totalled 941 and first aid cases 1439, making a total of 2380 accidents. The total number of man hours worked up to and including the week of May 31 was 6,292,568. Three fatal compensable accidents had been reported up to June 28.

— OSMJ —

Ruling on Appointment of Health Commissioners

The appointment by a district board of health of a health commissioner who is a partner of one of the members of the board which made the appointment is illegal and void, according to an opinion rendered recently by Attorney General John W. Bricker.

In support of his ruling, Mr. Bricker pointed out that although the statutes governing the appointment of a district health commissioner do not expressly provide that no member of the board of health may be interested directly, or indirectly, in contracts made by the board, as do the statutes with respect to members of boards of education and boards of county commissioners and certain other public officers, "it is a principle of common law that a public office is a public trust and cannot lawfully be administered for the personal profit of the incumbent".

In the same opinion, the Attorney General held that under the terms of the statutes governing the appointment of a district health commissioner such appointment may lawfully be made for such period of time prescribed by the statutes regardless of whether or not such period of time will extend beyond the official life of the appointing power.

Citing Section 1261-19, Mr. Bricker pointed out that this statute authorizes the appointment of a district health commissioner for a period of time as long as two years and that an appointment made for no longer than the period is not invalid even though the term of the health commissioner would extend beyond the life of the board making such appointment and into the term of the succeeding board of health.

— OSMJ —

Jackson—Dr. Gwyn Parry, who recently completed his internship at Johns Hopkins Hospital, Baltimore, has become an associate of Dr. W. R. Riddell, this city.

IMPROVEMENTS IN WORKMEN'S COMPENSATION ADMINISTRATION ARE INAUGURATED

Some expansion and improvement in the personnel of the various departments at the State Industrial Commission were made possible through the enactment of an appropriations measure at the recent special session of the Ohio General Assembly on building and loan legislation, allotting to the Commission an additional $125,000 for operating expenses during the remainder of 1934.

Action of the Legislature was in line with forceful recommendations of the Governor's Investigating Committee on Workmen's Compensation for a supplemental appropriation to be used in employing additional personnel for undermanned departments at the Commission. In its preliminary report to Governor White (May, 1934, issue *The Journal*, page 318-320), the special committee made a strong plea for more adequate funds annually for carrying on the operations of the Commission, pointing out that many of the difficulties in connection with the administration of the Workmen's Compensation Law are the result of an insufficient number of employes and the low salary schedule for employes holding positions entailing important responsibilities.

As a result of statutory changes made by the Legislature last April, chief of which was the transfer of administrative authority in workmen's compensation matters from the Director of Industrial Relations to the State Industrial Commission, the Commission has started gradual reorganization of the administrative machinery with a view to promoting greater efficiency in the handling of compensation claims.

In the June issue of *The Ohio Industrial Commission Monitor*, official monthly publication of the Commission, recent legislation affecting the Commission is analyzed and a few of the reorganization plans of the Commission commented upon.

After summarizing the provisions of the act restoring to the Commission full power and authority to administer the Workmen's Compensation Law, *The Monitor* stated:

"Acting under the authority designated by the act, the Industrial Commission on May 15, 1934, assumed authority over the personnel and the unexpended balance in the appropriation heretofore made to the Division of Workmen's Compensation of the Department of Industrial Relations, its first exercise of authority being the appointment of Albert D. Caddell of Mansfield, as secretary and the issuance of notices to all individuals included in the personnel familiar with the administration of the Workmen's Compensation Law that they were temporarily employed at prevailing rates of pay to carry on the duties they have heretofore performed. This action was deemed essential, owing to the ruling of the Attorney General that the law authorizing the transfer of authority and appropriations did not transfer the personnel, who were all automatically out of the service, and that appointments would necessarily have to be made by the Industrial Commission.

"Thus the Commission, on May 15, was confronted with the problem of setting up an entire administrative organization and attempting to put into effect the views of the special committee which secured the enactment of the law, handicapped by the failure of the law to provide additional appropriations which would permit of an expansion of personnel even up to the standard of recent years, when drastic reductions were made to the man-power deemed essential to an efficient and economical administration of the Workmen's Compensation Law. (Note: The article was written previous to enactment of the $125,000 appropriations measure).

"Under the new management, the demands of the Commission will be for efficiency and its consistent contention that the Workmen's Compensation Fund is a trust too sacred to be made the football of politics will be maintained. Changes in personnel, if any, will be based solely upon the good of the service and with the view of strengthening the fund and expediting its operation in the interest of its beneficiaries to the fullest extent that an inadequate personnel and restricted appropriations will permit.

"The appointment of Mr. Caddell as secretary of the Commission is evidence of the promptness and clarity with which the Commission recognized its new responsibilities. This position now becomes one of vital importance and one requiring the services of a capable organizer and an efficient administrator in whom the Commission can place perfect reliance in the carrying out of its wishes. Judged by the standards of personality, experience and background, Mr. Caddell meets every requirement for the place. ***

"With the prospect of enabling legislation making provisions for the funds absolutely necessary to expand the efforts and increase the efficiency of the service, the new administration of the Workmen's Compensation Fund will eventually bring about conditions more satisfactory to both employers and claimants and give added stability to the fund. Pending such time as appropriations meet the requirements of an expanded service, patience and full consideration of circumstances should direct the attitude of

those having dealings with the Commission. In the meantime, every effort humanly possible will be made, with such facilities as are at the disposal of the Commission, to improve the service and in so doing take into consideration the many constructive suggestions that have been offered for the betterment of the administration and operation of the law."

The Governor's Investigating Committee on Workmen's Compensation is now assembling data preparatory to making its final report to the Governor sometime in the Fall. It has concluded a series of public hearings in different parts of the state and is engaged in investigations of other phases of the administration and operation of the compensation law. Numerous additional constructive and comprehensive recommendations for improvement of the law itself and its administration, based on its findings, have already been tentatively agreed upon by the special committee and will be incorporated in its final report.

As reported by the Special Committee on Workmen's Compensation of the Ohio State Medical Association to the Council of the State Association at the meeting of the Council, July 8 (See Council minutes, page 513 this issue), the Governor's committee has requested the cooperation and advice of the State Association on medical aspects of its investigation. Reports and recommendations supplementing the report submitted by the State Association Workmen's Compensation Committe to the Governor's committee last April (May, 1934, issue *The Journal*, page 318) have been requested by the Governor's committee and are now being formulated for early presentation to the investigating committee.

— OSMJ —

No authority at law exists under which a proxy may vote in a meeting of a health district advisory council, according to an opinion rendered by Attorney General John W. Bricker. The question arose at a meeting of a county advisory council at which a member of the district board of health was elected by counting 13 votes of legally constituted members of the advisory council and the votes of two persons acting as proxies for two absent members. In his opinion, Mr. Bricker stated that there is no legal authority for a member of a district advisory council, created under Section 1261-18, et seq., who is absent from a regular or special meeting of such council, to vote by proxy and since there is no specific authority for voting by proxy, any votes so cast are void and should not be counted in any action taken by the council or in determining whether a quorum was present.

— OSMJ —

—Lakewood City Council has voted to issue bonds amounting to $40,000 for improvements at Lakewood Municipal Hospital.

Over Two Hundred New Physicians Are Licensed in Ohio

Two hundred and twenty-four physicians who took the June examinations given by the State Medical Board were granted licenses to practice medicine and surgery in Ohio at the regular meeting of the Board, held in Columbus on July 12.

In addition, seven physicians who had passed the December, 1933, examinations were given licenses, making the total number of licenses authorized by the Board 231. Licenses also were granted to 16 osteopaths.

Certificates to practice their respective limited branches were granted to three chiropractors, two mechanotherapists, five cosmetictherapists, 10 masseurs, and four chiropodists.

During the business session of the Board, Dr. L. T. Franklin, Chillicothe, newly-appointed eclectic member of the Board to succeed Dr. J. Stewart Hagen, Cincinnati, was sworn in.

The rules and regulations governing limited practitioners were amended by addition of a regulation that no limited practitioner shall announce himself as practicing a specialty.

The certificates to practice in Ohio of the following were revoked:

Ruth C. Schweisberger, M.D., Canton, on a charge of conviction of a felony.

Franklin E. Kerr, Toledo, osteopath, on a charge of conviction of a felony and grossly unprofessional conduct.

C. L. Ballinger, osteopath, Medina, charged with gross immorality, based upon repeated violations of the limitations placed on the practice of osetopathy.

D. E. Quilter, Tiffin, chiropractor and mechanotherapist, charged with grossly unprofessional conduct.

Clyde M. Figley, Akron, chiropractor and mechanotherapist, charged with grossly unproffesional conduct.

The highest grade in the June examinations was made by Jack Widrich, Cleveland, Ohio State University, College of Medicine, with an average of 88.8 per cent. Second, third and fourth places in the examination also were taken by graduates of the Ohio State University, College of Medicine, namely: Lena S. Enright, Columbus, 87.2 per cent; Reuben R. Pliskin, Akron, 86.4 per cent, and William M. Mewborn, Toledo, 85.9 per cent.

Those awarded licenses in medicine and surgery as a result of the June examinations were:

Ohio State University—Chester H. Allen, Portsmouth; Hubert M. Amstutz, Columbus; Willard B. Andrus, Columbus; John B. Berkebile, Jewell; Edgar K. Black, Columbus; Arthur A. Brown, Amanda; Donald H. Bullock, Columbus; Daniel S. Bunner, Columbus; Charles R. Burbacher, Columbus; Davin R. Cahill, Steubenville; Louis P. Cassady, Dresden; Everett M. Chalker, Garrettsville; Jacob Cohen, Steubenville; Thomas R. Cunningham, Findlay; Mel A. Davis, Hilliards;

William Davis, Cleveland; Camille J. DeLor, Columbus; Elmer D. Engelman, Cleveland Heights; Lena S. Enright, Columbus; Merrill W. Everhart, Columbus; John G. Feder, Galloway; Joe A. Fergus, Sidney; Joseph L. Friedman, Cleveland; George E. Gardner, Lancaster; William M. Garrett, Columbus; Robert T. Gillis, Martins Ferry; Reuben A. Glazer, Cleveland; Harry R. Grau, Cleveland; Walter K. Gregg, Columbus; Frank A. Hale, Columbus; Arvine W. Harrold, Fostoria; Joe F. Hattenbach, Columbus; John E. Hendricks, Newark; Joseph M. Hertzberg, Toledo; Luther W. High, New Washington; Paul I. Hoxworth, Columbus; Fred J. Hunter, Columbus; Waudell W. Hunter, Columbus; Elmer M. Kilpatrick, Columbus; Gilman D. Kirk, Orient; Robert C. Kirk, Columbus; Joseph W. Kohn, Cleveland; Thomas V. Kolb, Columbus; Luette H. Kuhlman, Toledo; Leo M. Levin, Cleveland; Harold A. Lotzoff, Lima; Thurman F. McAllister, Birds Run; George L. McCullough, Pomeroy; Alexander S. Mack, Toledo; Carl J. Mankinen, Ashtabula; Francis E. Merritt, Columbus; William M. Mewborn, Toledo; Malcolm E. Miller, Ashland; Edward L. Montgomery, Xenia; Morris Montlack, Cleveland; John A. Murphy, Jr., East Liverpool; Frank M. Natherson, Parma; Reubin R. Pliskin, Akron; Clark P. Pritchett, Columbus; Lloyd W. Reynolds, Akron; John A. Riebel, II, Columbus; George R. Roberts, Columbus; Ralph S. Rosewater, Cleveland Heights; Theodore D. Sawyer, Circleville; Allan L. Schaffer, Lakewood; Marion R. Shafer, Columbus; Lee Sharp, Cadiz; Maurice V. Sheets, Columbus; Clifford C. Sheldon, Fostoria; Lewis S. Shensa, Youngstown; John P. Smarella, Steubenville; Earl E. Smith, Cleveland Heights; Louis T. Spohr, Columbus; John B. Squires, Cincinnati; Myron H. Steinberg, Columbus; Alfred E. Stout, Dayton; Cyril T. Surington, Cleveland; William Tandy, Dayton; Russell E. Taylor, Sandusky; Charles H. Thompson, Columbus; Donald M. Traul, Akron; Joseph D. VandeVelde, Cleveland; Nancy S. Whitticar, Columbus; Jack Widrich, Cleveland; Benjamin F. Wills, Jr., Wellston; Robert H. Zeis, Kenton.

University of Cincinnati—Robert S. Alcorn, Cincinnati; Lynne E. Baker, West Milton; Taylor W. Barker, Cincinnati; Michael Barrett, Cincinnati; Erwin C. Binstadt, Cincinnati; Herbert J. Brinker, Cincinnati; Ballard F. Combs, Cincinnati; Walter R. Cook, Cincinnati; Nelson R. Cragg, Cincinnati; Louis J. Crum, Cincinnati; Marion I. Davis, Cincinnati; John A. DeBold, Norwood;Robert F. Donley, Columbus; August F. Fath, Cincinnati; Walter Felson, Cincinnati; Ellis Flax, Cincinnati; Edward J. Geiser, Cheviot; Herbert D. Glick, Cincinnati; Helen I. Glueck, Cincinnati; Philip P. Goland, Cincinnati; Sidney N. Goldstein, Cleveland; David L. Graller, Cincinnati; Frederick W. Gross, Cincinnati; Albert P. Harrison, Cincinnati; Virgil D. Hauenstein, Troy; Leonard A. Hautzenroeder, Cincinnati; Elliot A. Hilsinger, Cincinnati; David L. Hirst, Cincinnati; Lloyd W. Hisrich, Cincinnati; Richard B. Homan, Cincinnati; William I. Huesing, Cincinnati; Maurice Hyman, Jr., Cincinnati; Ralph J. Johansmann, Cincinnati; Charlotte M. Johnson, Cincinnati; Daniel V. Jones, Norwood; William J. Kennedy, Norwood; Robert E. Khuon, Cincinnati; Maynard C. Kiser, Dayton; Lawrence Klein, Cincinnati; Harold W. Klewer, Toledo; Louis E. Kroger, Hamilton; Lloyd E. Larrick, Cincinnati; Sanford P. Lehman, Cincinnati; Justus H. Loeb, Dayton; Louis C. Loeber, Dayton; Wells C. McCann, Portsmouth; Henrietta M. Miller, Cincinnati; Lester A. Mount, Cincinnati; Herman J. Nimitz, Cincinnati; Howard J. Ohl, Cincinnati; J. Philip Owens, Cincinnati; Milton Rosenbaum, Cincinnati; Stuart A. Schloss, Cincinnati; Gerald T. Schwarz, Akron; Isadore C. Sharon, Cincinnati; Vinton E. Siler, West Manchester; Robert D. Snyder, Dayton; Charles C. Sonnemann, Cincinnati; George W. Speed, Springfield; John T. Sprague, Columbus; Katherine Stewart, Cincinnati; William J. Tennison, Cincinnati; James Tiery, Jr., Dayton; Earl C. VanHorn, Cincinnati; Edwin B. Weinstein, Middletown; Stanley Weinstein, Cincinnati; Alois H. Willke, Cincinnati; G. Howard Wood, Cincinnati; Herbert E. Wyss, Cheviot; Isadore Zeligs, Cincinnati.

Western Reserve University—Marshall H. Aiken, Cleveland; William A. Avery, Rocky River; Robert R. Boice, Middleport; Donald W. Briceland, Cleveland; Ronald R. Bushyager, Cleveland; Paul C. Crone, Cleveland; Homer J. Daus, Cleveland; Anthony J. Dicello, South Euclid; Gertrude C. Donnelly, Lakewood; John E. Dougherty, Canton; Clarence C. Engleman, Kent; Isadore S. Epstein, Cleveland; Ann A. Filak, Cleveland; Ben Fisher, Cleveland; Julian B. Galvin, Shaker Heights; Robert L. Gettman, Columbus Grove; Morton L. Goldhamer, Cleveland Heights; Warren W. Hale, Cleveland; Volta R. Hall, Jr., East Cleveland; Harry A. Haller, Cleveland; Carl A. Hamann, Cleveland Heights; Robert W. Heinle, Willoughby; John A. Heppl, Cleveland; Joseph H. Holmes, Fremont; George E. Huston, Cleveland; Paul N. Ivins, Hamilton; James H. Jewell, Cleveland; John S. Kiess, Cleveland; Karl E. Kimber, Springfield; Edward M. Kline, Steubenville; Robert H. Lechner, Berea; Robert D. Mansfield, Canton; Myles R. Miller, Cleveland; Harry Morris, Cleveland; John A. Murphy, Youngstown; Francis R. Neff, St. Clairsville; Holger C. M. Nelson, Cleveland; Jacob E. Palomaki, Warren; Herbert P. Ramsayer, Youngstown; William Randolph, Cleveland; Richard B. Robrock, Cleveland; Carl W. Rotter, Cleveland; Edward D. Schwartz, Cleveland; Milton R. Schwartz, Cleveland; James F. Seliskar, Cleveland; Walter M. Solomon, Cleveland; Clifford J. Vogt, Shaker Heights; George J. Votava, Cleveland; Milton P. Wallenstein, Cleveland; Joseph J. Wasilko, Cleveland; Thomas W. Watson, Old Fort; Howard T. White, Cleveland; Ben Widzer, Cleveland; David J. Zaugg, Cleveland.

Other Schools—William H. Eberle, Ashtabula, Cornell University; Orrin E. Anderson, New York, Cornell University; Charles J. McDonald, Cleveland, Creighton University; Abraham W. Chernoff, Cleveland, Tufts Medical College; Carrol S. Small, Columbus, College of Medical Evangelists; John R. Hague, Cleveland, Hahnemann Medical College; John G. Fleming, Cincinnati, Harvard Medical College; Edmund S. Young, Columbus, Harvard Medical College; Kenneth W. Keever, Belpre, Jefferson Medical College; Benjamin M. Avellone, Cleveland, Loyola Medical School; Ladislaus Kunsch, Cleveland, Loyola Medical School; Elmer R. Torrence, Cincinnati, Northwestern University; Albert C. Sunseri, Steubenville, University of Pittsburgh; William E. Callison, Cincinnati, Yale University School of Medicine.

Those granted licenses as a result of the December, 1933, examinations were: Craig C. Wales, Cleveland, Rush Medical College; David Taylor, Dayton, Rush Medical College; Harold D. Boc-

koven, Phillipsburg, Rush Medical College; Nicholas M. Tsaloff, Akron, Loyola University; Frank R. Schirripa, Cleveland, Loyola; William N. Macey, Cleveland, Loyola; and George T. Day, Cleveland, Loyola.



OHIO DEATHS

David E. Bowman, M.D., Toledo; University of Michigan Medical School, 1881; aged 77; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 21. Dr. Bowman had practiced in Toledo for 40 years. He was a member of the faculty of the old Toledo Medical College for many years. Surviving are his widow, one son, Dr. Galen Bowman, Toledo; one daughter, and three brothers, Dr. J. H. Bowman, Vickery; Dr. J. Charles Bowman, Genoa, and Dr. A. L. Bowman, Martin.

Joseph E. Brown, M.D., Cincinnati; Cincinnati College of Medicine and Surgery, 1892; aged 67; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 3. Surviving are his widow and one daughter.

Henrietta Buchanan, M.D., Cincinnati; Woman's Medical College, Cincinnati, 1894; aged 78; died June 11. Dr. Buchanan had retired from active practice about 20 years ago. Surviving are one son and one daughter.

Jefferson N. Drennen, M.D., Lloydsville; Cleveland College of Physicians and Surgeons, 1890; aged 71; member of the Ohio State Medical Association and the American Medical Association; died June 26 of heart disease. Dr. Drennen was a native of Belmont County and spent his entire life there. He was an active member of the county medical society and the United Presbyterian Church. Surviving are his widow, two brothers and one sister.

Thomas Fitzpatrick, M.D., Norwood; Cincinnati College of Medicine and Surgery, 1875; aged 79; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died June 25 of heart disease. Dr. Fitzpatrick was a former mayor of Norwood and was active in the Masonic Lodge, having been a founder of the Norwood lodge. Surviving are two sons.

Constantine Gale, M.D., Zanesville; Jefferson Medical College, 1878; aged 84; died June 28 at the home of his brother at Newport. Dr. Gale retired from active practice 15 years ago at New Brighton, Pa., and moved to Zanesville. He was a native of Newport. Surviving are his widow, one brother, Dr. George T. Gale, Newport, and one nephew, Dr. George H. Gale, Newport.

William H. Kinnicut, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1898; aged 70; died June 22. Surviving are his widow, one son and one daughter.

Charles H. McFarland, M.D., Cleveland; licensed in 1899; aged 84; died June 10. Surviving are two daughters.

M. M. Morrow, M.D., Donnelsville; Eclectic Medical College, Cincinnati, 1885; aged 73; member of the Ohio State Medical Association and the American Medical Association; died June 27. Dr. Morrow had practiced in Clark County for 49 years. He was a former county health commissioner and surgeon for the International Harvester Company. Surviving are his widow, two sons, one daughter, two sisters and one brother.

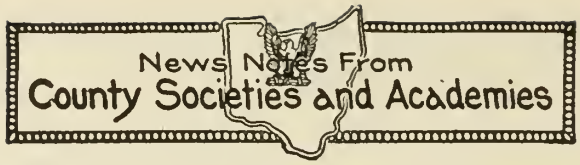
James L. Neave, M.D., Dresden; Miami Medical College, Cincinnati, 1874; aged 84; died June 17. Dr. Neave was retired from active practice, after 40 years' practice at Dresden. Surviving are one son and one daughter.

Charles G. Parker, M.D., Gallipolis; Medical College of Ohio, Cincinnati, 1888; aged 76, died June 12 on the anniversary of the death of his brother, Dr. E. W. Parker. Dr. Parker was active in the affairs of the Methodist Episcopal Church. He was a native of Porter where he practiced until 1891 when he moved to Gallipolis. Dr. Parker was a former county coroner and served on the draft board during the World War. Surviving are his widow and one sister.

Elmer O. Richardson, M.D., Marion; Columbus Medical College, 1884; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died July 6 of cerebral hemorrhage. Dr. Richardson had retired from active practice five years ago. He was organizer of Company D, Ohio National Guard, in 1907 and was captain of the company until 1914. He was a member of the Masonic, Elks and Pythian lodges and a former member of the American Academy of Ophthalmology and National Association of Pension Examiners. Surviving is one sister.

Frank L. Riegel, M.D., Springfield; Columbus Medical College, 1891; aged 74; died June 28. Dr. Riegel was a native of Clark County and had practiced there until his recent retirement. Surviving is one daughter.

William S. Wire, M.D., Norwood; University of Cincinnati, College of Medicine, 1929; aged 30; member of the Ohio State Medical Association; and the American Medical Association; died June 2 of heart disease. Surviving are his widow, one son, one daughter, and his parents.



First District

Adams County Medical Society met on June 27 at West Union. The morning program consisted of a paper on "Scarlet Fever Prevention" by Dr. S. J. Ellison, West Union, and a discussion of the paper by Dr. Hazel Sproull, West Union. Following luncheon at the North Side Hotel, the following program was presented: "Experiences in Russia with the American Relief Expedition", Dr. M. D. Godfrey, Columbus; "How Best to Make and Preserve Clinical Records in Rural Practice", Dr. L. H. Leonard, Manchester; discussion, Dr. George P. Tyler, Manchester; "Medical Relief Problems", Mrs. Ruth Stroth. Dr. Godfrey also gave an *X*-ray exhibit of gallbladder diseases.—Bulletin.

Second District

Greene County Medical Society in session July 6 at Xenia was addressed by Dr. Warren C. Breidenbach, Stillwater Sanitarium, Dayton. Following his address on "Tuberculosis", a round table discussion was held.—News Clipping.

Third District

Auglaize County Medical Society held its regular meeting on July 12 at Wapakoneta with an attendance of 25. Dr. H. H. McClellan, Dayton, gave an illustrated lecture on "Physical Causes of Mental and Nervous Diseases". Dr. George B. Faulder, Wapakoneta, spoke on "Version vs. Forceps". It was voted to hold the next meeting following the State Association Annual Meeting in October.—C. C. Berlin, M.D., secretary.

Mercer County Medical Society held a dinner meeting June 26 at the Manhattan Hotel, Celina. The guest speakers were Dr. F. G. Maurer and Dr. E. H. Hedges, Lima.—News Clipping.

Sixth District

Stark County Medical Society held its annual picnic on June 27 at the Congress Lake Country Club. The program consisted of golf, fishing and bridge, followed by a dinner in the evening.—Bulletin.

Seventh District

Tuscarawas County Medical Society in session July 12 at Dover received reports from those who attended the American Medical Association meeting in Cleveland.—Bulletin.

Eighth District

Annual meeting of the Eighth District Medical Society was held June 21 at the Rocky Glen Sanatorium, McConnelsville.

The following scientific program was presented:

"Surgical Aspects of Ulcers and Cancers of the Stomach", Dr. Verne Dodd, Columbus; "Nutritional Fads and Facts from the Viewpoint of the Clinician", Dr. Arthur G. Helmick, Columbus; "Collapse Therapy in Tuberculosis", Dr. J. M. Appel, Cleveland; "Amoebic Dysentery", Dr. Reo M. Swan, Cambridge; "Intercranial Hemorrhage", Dr. Harry LeFever, Columbus.

At the business session, Dr. D. G. Ralston, McConnelsville, was elected president, succeeding Dr. B. A. Souders, Cambridge. Dr. C. E. Northrup, McConnelsville, was elected secretary, succeeding Dr. Reo M. Swan, Cambridge.

At the luncheon, addresses were made by Dr. E. R. Brush, Zanesville, councilor of the Eighth District; Dr. E. LeFever, Athens, veteran member of the Ohio Senate; Dr. H. G. Southard, State Director of Health, James E. Bauman, assistant State Director of Health, and Dr. Louis Mark, medical director, and H. A. Phillips, superintendent, of the Rocky Glen Sanatorium.—News Clipping.

Guernsey County Medical Society was addressed on July 19 by Dr. M. S. Lawrence, Cambridge.

On July 12 the members of the society and their wives were entertained at the Swan Hospital.—Bulletin.

Perry County Medical Society met July 16 at the Park Hotel, New Lexington with Dr. Charles J. Shepard, Columbus, as guest speaker.—Bulletin.

Washington County Medical Society was entertained on June 20 at Memorial Hospital with motion pictures, "The Art and Science of Obstetrics", taken at the Chicago Lying-In Hospital.—Bulletin.

Ninth District

Scioto County—The Hempstead Academy of Medicine was addressed on July 9 by Howard Williamson, D.D.S., Portsmouth, on "Infections of the Mouth". A buffet supper was served following the program.—Bulletin.

— OSMJ —

—Dr. J. W. Stout has been re-elected chief of staff at St. Anthony's Hospital, Columbus. Dr. C. J. Shepard was elected presiding officer at staff meetings; Dr. Carl D. Postle, vice president, and Dr. Paul Ross, secretary-treasurer.

NEWS NOTES of OHIO

Akron—Dr. Harry S. Davidson, Akron, Councilor of the Sixth District, Ohio State Medical Association and a former member of the House of Representatives, Ohio General Assembly, is a candidate for coroner of Summit County in the Republican primary election.

Columbus—Dr. John Mitchell, secretary of the Columbus Academy of Medicine, has resumed active practice at 3042 North High Street, Columbus, following his recovery from an extended illness. Dr. Mitchell will devote special attention to the treatment of asthma, hay fever, eczema and allied manifestations of allergy.

Cincinnati—Dr. Fred W. Heinhold, Cincinnati, has been elected president of the Alumni Council, University of Cincinnati.

Columbus—Dr. Sterling B. Taylor and Dr. George T. Harding, III, attended the annual meeting of the American Railway Surgeons Association at Washington, D. C. Dr. Taylor reported on the results of health examinations given 500,000 railway employes, a project sponsored by a special committee of which he is chairman. Dr. Harding addressed the meeting on "Slow Cerebration".

Perrysville—Dr. E. L. Jackson, formerly of Cleveland, has opened offices here.

Springfield—Announcement has been made of the marriage of Miss Mildred Everhart, Mechanicsburg, to Dr. G. M. Lane, Springfield.

Cleveland—Dr. B. B. Kimmel and Dr. H. F. Staples, both of this city, were elected president-elect and first vice president, respectively, of the American Institute of Homeopathy at the annual meeting of the institute in Detroit.

Bethel—Dr. W. E. Thompson, believed to be the oldest practicing physician in the United States, recently celebrated his 99th birthday.

Columbus—Dr. Frank A. Hartman, discoverer of cortin, a treatment for Addison's disease, and a member of the faculty at the University of Buffalo for many years, has accepted an appointment as professor of physiology at Ohio State University.

Coshocton—Dr. Roy D. Hildebrand has resumed active practice following postgraduate work at Harvard Medical School.

Cincinnati—Dr. Charles D. Aring, formerly of Cincinnati, has been awarded the Sterling fellowship in neurology at Yale University, School of Medicine. For the past year he has been chief resident physician at Boston City Hospital and instructor in neurology at Harvard Medical School.

Mansfield—Dr. S. C. Schiller is taking postgraduate work in heart disease at Peter Bent Brigham Hospital, Boston.

Sciotoville—Dr. William Hartlage, recently an intern at St. Elizabeth's Hospital, Dayton, has opened offices here.

Portsmouth—Dr. W. A. Braunlin has been elected commander of Calvary Commandery, No. 13, Knights Templar.

West Milton—Announcement has been made of the marriage of Miss Helen Bradley, Dayton, and Dr. Charles Baker, West Milton.

Marion—Dr. D. W. Brickley, Jr., who has completed his internship and residency at St. Luke's Hospital, Cleveland, has joined his father, Dr. D. W. Brickley, in eye, ear, nose and throat practice here.

Cincinnati—An anonymous gift of $1,000 to the College of Medicine, University of Cincinnati, will be used to further research work in serums being conducted by Dr. Lee Foshay.

St. Paris—Dr. John F. Hamsher has been elected president of the local Lions' Club.

Cedarville—Dr. K. F. Johnston, formerly an intern at St. Mary's Hospital, Cincinnati, has begun practice here.

East Liverpool—Dr. E. W. Miskall addressed 25 student nurses at the City Hospital on "Diabetes Mellitus".

Dennison—Dr. W. W. H. Curtiss addressed the local Rotary Club on "The Doctor's Profession".

Delphos—The Delphos Kiwanis Club was addressed by Dr. Edward W. Pedlow, Lima, on "Advances on Medicine".

McConnelsville—Dr. Edgar Northrup, son of Dr. and Mrs. C. E. Northrup, McConnelsville, has entered the United States Public Health Service and is stationed at the Government Hospital, Staten Island. He is a graduate of the College of Medicine, Ohio State University.

Winchester—Dr. F. C. Leeds has resigned as a member of the Winchester board of education after 14 years of service.

Alliance—Dr. Esther Maurer has been appointed assistant physician at the Molly Stark Sanatorium.

Plans Arranged For Annual Golf Tournament

Elaborate plans are being made for the Fourteenth Annual Tournament of the Ohio State Medical Golfers' Association to be held at the Columbus Country Club on Wednesday, October 3, the day preceding the opening of the 88th Annual Meeting of the Ohio State Medical Association in Columbus.

Dr. F. C. Haney, Columbus, president of the golfers' association is assisting Dr. Carl Hyer, chairman of the local committee in charge of the golf tournament and his committe, consisting of Drs. Frank Watson, John Thomas, Robert Nosker and William Drake, in completing the arrangements for the event.

If the plans of the local committee materialize, the Columbus tournament will be one of the largest and best ever held by the golfers' organization. Extensive publicity plans are under way. Cards will be mailed in the near future to all members of the golfers' association. Arrangements have been made with the Columbus Country Club to permit physicians intending to take part in the tournament to shoot a practice round any time previous to the date of the tournament. A large list of prizes for the many classes and events is being made up.

The Columbus Country Club course is one of the finest in Ohio. Its greens are among the best in the country and its fairways are always in excellent condition due to the effective watering system employed by the club. Although not an extremely difficult layout, it is a real test and affords much enjoyment for the duffer as well as the par-shooter.

Every male member of the Ohio State Medical Association is eligible to membership in the golfers' association and to participate in the tournament on payment of an enrollment fee of $2.00 which makes him a life member. The tournament fees are reasonable. Those wishing to join the association may mail their check for $2.00 to Dr. J. B. Morgan, secretary of the golfers' association, Medical Arts Building, Cleveland, or pay it when teeing off on the morning of October 3.

Dr. R. P. Bell, Cleveland, is the present champion of Ohio's physician golfers. He won the tournament held last year at Akron with a medal score of 154. Undoubtedly Dr. Bell will be on hand to defend his crown.

Officers of the golfers' association are: President, Dr. Haney; first vice president, Dr. J. F. Wright, Toledo; second vice president, Dr. C. F. Wharton, Akron; third vice president, Dr. F. C. Anderson, Mt. Vernon; fourth vice president, Dr. W. E. Dwyer, Cleveland; fifth vice president, Dr. E. Gillespie, Canton; secretary-treasurer, Dr. Morgan.

Timely Warning Concerning Collection Agency Rackets

Complaints from physicians in various parts of the state indicate that questionable and racketeering collection and so-called professional financing companies are making another raid on the medical profession of Ohio.

Periodically the medical profession is pestered by representatives of gyp agencies of this type, most of whom ply their trade on a national scale. Unfortunately, a considerable number of physicians annually fall for the high-powered sales talk of advance men for such agencies. Old and delinquent accounts are sold or turned over to some agency of doubtful standing or some complicated scheme for financing accounts is subscribed to with the result that eventually the physician finds he has purchased a gold brick or jeopardized the good will and friendship of patients as a result of the insulting and threatening letters sent out by the agency.

Repeated warnings to physicians regarding collection and financing schemes have been issued through *The Journal* and otherwise. In the 1932 report of the Committee on Medical Economics considerable space was devoted to this question. (May, 1932, issue *The Journal*). Other articles on the same general subject were published in *The Journal* as follows: December, 1932; July, 1932; November, 1931; September, 1931; November, 1930; October, 1930; July, 1930; March, 1930, and October, 1929. In addition, similar information and advice is published frequently in *The Bulletin of the American Medical Association.*

Briefly, to play safe in the matter of collecting or financing accounts, the physician should bear in mind the following general points:

1. Avoid doing business with strangers and agencies on which authentic information regarding their business standing, financial status and reputation is lacking.

2. For the most part, avoid doing business with nation-wide agencies. There are some exceptions to this. However, in most instances more satisfactory service is given by local collecting firms or individuals engaged in such work. At least, in engaging local firms the physician can check up on the type of service rendered and the reputation of the concern.

3. Avoid signing contracts or agreements. All contracts are not traps but many of them are, so to be on the safe side, a physician should refuse to sign any.

4. Obtain thorough information regarding the methods used by any agency employed; what results it has had, etc. Also, read carefully the type of literature sent out by it and have a thorough understanding of all financial arrangements.

5. As in all other business activities, investigate carefully before investing.

In this connection, Ohio physicians will be interested in a recent bulletin broadcast by the Columbus Better Business Bureau, Inc., entitled, "Local Professional Men Are Offered Unquestionable Collection Contract". The bulletin in part stated:

"Many inquiries have been received recently by the Better Business Bureau from professional men in the Columbus territory regarding the Birdsell Loan and Finance Company, Inc., and the Affiliated Underwriters Loan and Finance Company, Inc., both of 1515 Sherman Avenue, Evanston, Illinois. These concerns are said to be operated by A. E. Birdsell, who, in the words of the Indianapolis Better Business Bureau, "has been successful in fooling a multitude of business and professional men through his collection agency schemes.

"The contracts offered by these two companies are almost identical. The business or professional man does not merely turn over his accounts to the company for collection. He assigns and sells them subject to the company's discretion in settlement under a wide latitude of terms and conditions. He empowers and authorizes the company his sole agent, and attorney-in-fact, for the purpose of endorsing all papers of any kind or nature that may come into the company's possession. He also gives the company full power and authorization to settle, receipt and endorse any checks or notes for the purpose of settling the accounts. Complaints indicate a wide-spread failure to read or understand the contract provisions as well as discrepancies between what the representative is said to have promised and what the contract calls for.

"The commissions withheld by the company for the collection of accounts appear to be moderate on casual reading of the contract—only 25% to 40%. However, many fail to grasp the meaning of the word 'aggregate' as used in the contract, wherein it is provided that the company's commission is .....% of the 'aggregate amount listed'. ***

"Birdsell's companies in the past have failed to answer letters directed to them by Better Business Bureaus."

More detailed information regarding this particular agency will be found in an article published in the March 31, 1934 issue of *The Journal of the American Medical Association*, page 1087.

When it comes to collections, the physician will find it much safer to make use of local firms and services whose reputation is well known or continue his own collections than to employ some little-known firm, operating nationally and with a high-sounding title.

Efforts Made Through Publicity for More Complete Pre-Natal Care

In line with conclusions of the medical profession that competent pre-natal care is one of the most effective ways of reducing mortality and morbidity during pregnancy and childbirth, a point that has been repeatedly emphasized by the Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical Association, the State Department of Health recently formulated a bulletin on this important question for the information of the public and released it to the newspapers of the state through the different local health departments.

The news release emphasized the value of adequate medical care of the expectant mother and pointed out ways pregnant women can cooperate with the medical profession in its efforts to reduce the mortality and morbidity rates of pregnancy and childbirth. It was as follows:

"A considerable number of the deaths of women during pregnancy, labor, or following childbirth in Ohio annually could be prevented if all prospective mothers would avail themselves of competent medical care during pregnancy, according to a bulletin issued today by the State Department of Health in connection with a summary of a 20-years study of maternal mortality in this state.

"The study reveals that during the past 20 years, 1914 to 1933, inclusive, 15,965 women died as a result of their pregnancies. The average annual death rate from puerperal causes for the period was 13.39 per 100,000 population, ranging from a high rate of 22.20 in 1918 to a low of 8.04 in 1933.

"It was pointed out that morbidity (illness or disability) resulting from pregnancy cannot be measured collectively but that it has been conservatively estimated that for every woman who dies as a result of pregnancy at least 15 others suffer physical impairments that result in partial disability or invalidism, as a result of insufficient pre-natal care or proper facilities at birth.

"In emphasizing the fact that prompt and adequate pre-natal care is one of the biggest factors in the prevention of mortality and morbidity in pregnancy, the bulletin called attention to the warning and advice voiced recently by the Committee on Preventive Medicine of the Ohio State Medical Association that:

" 'Too frequently the natural process of birth becomes complicated because the expectant mother neglects to assure herself of a happy outcome. A properly conducted pregnancy and birth leads to a fortunate result, with a well mother and sound baby. Every pregnant woman should share this burden with her doctor by the closest cooperation and contact. Every prospective

mother should guard her own health and that of her baby.'

"The statement was released by Dr. ....., health commissioner of ..... (localize), who concurred in the advice offered and in the following recommendations made in the bulletin to prospective mothers as to how they can cooperate with their physicians in caring for them and aid in minimizing the chances of pregnancy difficulties:

"1. Go to your physician as soon as you suspect that a pregnancy has occurred, in order that he may make a thorough physical examination, take pelvic measurements, (in first pregnancy), examine the urine, and estimate the blood pressure.

"2. Talk over with him the routine of your daily life. Obtain instructions with regard to diet, rest, and elimination.

"3. See him as often as he suggests or oftener if you are not absolutely well. Be sure to take a specimen of urine whenever one is requested by the physician so that he may examine it when the blood pressure is taken.

"4. If you are unable to pay for individual care, find out if there is a pre-natal clinic in your community where you may go for instruction. A good many cities have established such clinics which also arrange for competent medical care at the time of birth for those who must be helped.

"5. Arrange for your care in a hospital for the baby's birth if you can possibly do so. If the baby is to be born at home you must have adequate nursing care and make proper provision for the doctor to do the best work of which he is capable.

"6. Allow your doctor to send you to a hospital if in his judgment this is indicated to cope with any complication of serious import, such as bleeding during your pregnancy.

"7. Go to your doctor before trouble begins and abide by his judgment."

— OSMJ —

Notes on The Now Famous Canadian Quintuplets

When Mrs. Ovila Dionne of North Bay, Ontario, two months ago gave birth to quintuplets, the course of human events was not altered for any one except the Dionne family.

Yet, few stories ever received more widespread circulation or packed a greater appeal to the emotions of persons in all walks of life than those regarding the birth of the five little Dionnes and the services performed at this unusual physiological event by Dr. A. R. Dafoe, the family physician.

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It is another example of the thrills and dramatic elements involved in the practice of medicine. Unusual, to be sure, was the birth of the quintuplets but typical was the drama attending the successful efforts of the homespun country doctor to save the life of the mother and the babies.

When Dr. Dafoe has the time he undoubtedly

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An interesting sidelight on the birth of the Dionne quintuplets is the publication in the July issue of *The Cleveland Academy of Medicine Bulletin* of two letters written by Dr. Dafoe to a Cleveland physician in reply to a letter asking Dr. Dafoe to publish the details of the delivery of the babies so that the medical profession might profit from his experience. The two letters follow:

"Dear Doctor,

"I feel that I must answer your letter. Babies were born in one-half hour; two complete in sacs. These remained for some minutes, while I tied off the first four. They looked interesting swimming around and kicking. The mother was apparently dying and pulseless. I expressed placenta. This was common to all cords, which entered the mass. Apparently a one ovum pregnancy. It looked no different from a one child delivery. Placenta was destroyed by the midwives. I was too busy with the mother to pay any more attention to the babies, etc. She recovered after an hour's work. Pituitrin, ergot, holding uterus, etc.—Am very busy these days.

Sincerely,
A. R. Defoe."

"Dear Doctor,

"I am glad that my few notes met with your approval. I have been busy, and perhaps they are not too plain.

"At present the children are improving slowly, but are a handful. Difficult to make them drink enough. They are fed every two hours, temperature of incubators is now kept at 82 degrees, using Taylor Humidiguides to keep the moisture at 50 to 55. Three single incubators, and one large one to hold two. Oxygen 96% and CO_2 5% administered four or five times a day as a routine. Oftener if they show cyanosis. Rum, one drop in milk—if and when needed as a stimulant. Children are only handled once a day to be oiled and cleaned and weighed. No one of course is allowed near them except the nurses with gown and mask. My inspections are only made through the glass.

"The mother in previous pregnancies (six) used to stay in bed only for three or four days. Difficult to keep her there now.

"Human milk is furnished me daily from Sick Children's Hospital, Toronto. Children are now taking 45 ounces per 24 hours.

"Sometime when not too busy I will try to

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make a full report which will probably be published in a Canadian Medical Journal. I see no objection to publishing a few notes in your Bulletin. Use your own judgment.

Sincerely,

Allan Roy Defoe."

HOSPITAL NOTES

—Staff officers and appointments at Charity Hospital, Cleveland, have been announced as follows:

Dr. J. P. Sawyer, honorary chief of staff; Dr. John Dickenson, chief of staff; Dr. O. A. Weber, vice chief of staff; Dr. F. C. Oldenburg, director of medicine; Dr. E. P. Neary, director of surgery; Dr. John D. Osmond, director of laboratories; Dr. H. H. Drysdale, member-at-large of executive committee; Dr. H. H. Shiras, secretary and treasurer.

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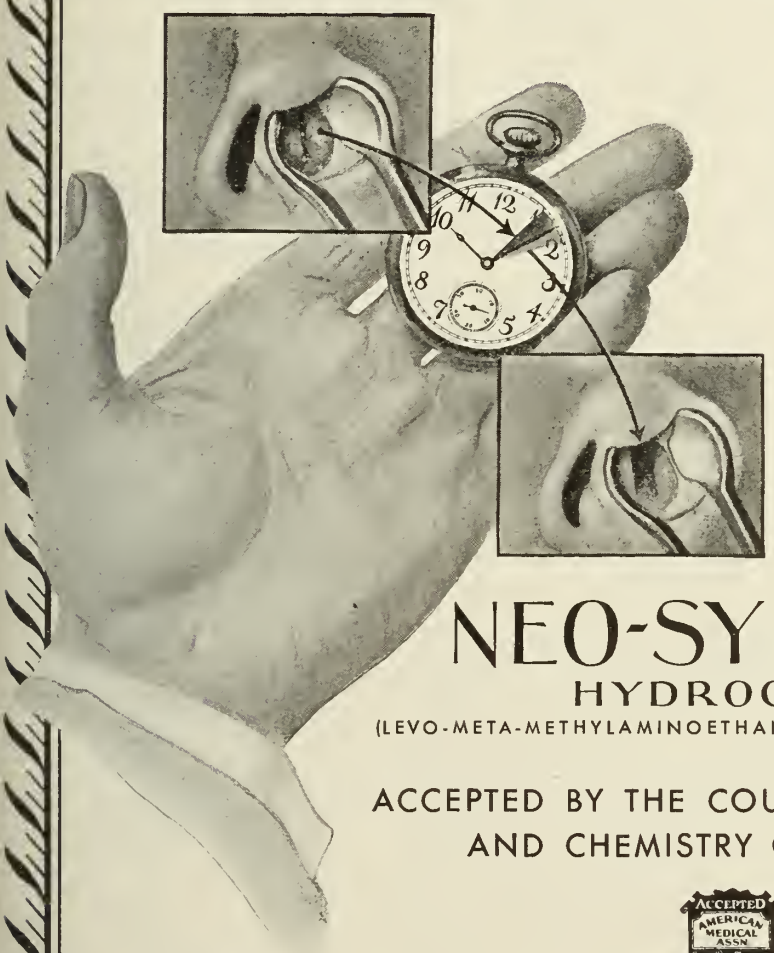
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— OSMJ —

—Four new interns at People's Hospital, Akron, are: Dr. J. Everett McFarling, Donna, Texas; Dr. Reuben A. Glaser, Cleveland; Dr. Paul Zwerner, Terre Haute, Indiana, and Dr. Edward N. Livingston, San Antonio, Texas.

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The OHIO STATE MEDICAL JOURNAL

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AS A MEDIUM OF SERVICE TO ITS MEMBERS

SEPTEMBER 1, 1934 VOLUME XXX
Number 9

Official Program of 88th Annual Meeting of State Association in This Issue

Schedule of Events and Special Attractions for Gathering in Columbus, Thursday, Friday and Saturday, October 4, 5 and 6, Including Hotel Information, Will be Found on Pages 580 to 595 Inclusive

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Butler	H. A. Moore, Oxford	V. E. Roden, Hamilton	2d Wednesday, monthly.
Clermont	Allan B. Rapp, Owensville	J. M. Coleman, Loveland	3d Wednesday, monthly.
Clinton	H. E. Gibson, Blanchester	E. W. Peelle, Wilmington	1st Tuesday, monthly.
Fayette	A. S. Stemler, Washington C. H.	J. F. Wilson, Washington C.H.	1st Thursday, quarterly
Hamilton	Samuel Iglauer, Cincinnati	H. F. Downing, Cincinnati	Monday evening of each week.
Highland	T. W. Roberds, Belfast	W. B. Roads, Hillsboro	1st Wednesday, monthly.
Warren	P. W. Tetrick, Mason	James Arnold, Lebanon	1st Tues. Apr., May, June, Sept., Oct., and Nov.
Second District	Cyril Hussey, Sidney	H. R. Huston, Dayton	
Champaign	Mark Houston, Urbana	L. A. Woodburn, Urbana	2d Thursday, monthly.
Clark	E. P. Greenawalt, Springfield	Roy D. Arn, Springfield	2d and 4th Wednesday noon.
Darke	B. F. Metcalf, Greenville	W. D. Bishop, Greenville	2nd Friday, monthly.
Greene	C. E. Ream, Bowersville	H. E. Ray, Xenia	1st Thursday, monthly.
Miami	W. W. Trostel, Piqua	G. A. Woodhouse, Pleasant Hill	1st Friday, monthly, except July and August.
Montgomery	C. D. Smith, Dayton	Miss M. E. Jeffrey, Dayton	1st & 3rd Friday, Oct. to June
Preble	J. B. Lucas, West Alexandria	C. E. McKinley, Camden	3d Thursday, monthly.
Shelby	A. R. Edwards, Sidney	S. C. Yinger, Sidney	1st Friday, monthly.
Third District	C. E. Hufford, Toledo	J. H. Marshall, Findlay	
Allen	J. R. Johnson, Lima	K. L. Parent, Lima	3d Tuesday, monthly.
Auglaize	E. F. Heffner, Wapakoneta	C. C. Berlin, Wapakoneta	2nd Thursday, bi-monthly.
Hancock	J. H. Marshall, Findlay	H. O. Crosby, Findlay	1st Thursday, monthly.
Hardin	F. M. Elliott, Ada	W. N. Mundy, Forest	3d Thursday, monthly.
Logan	John L. Maurer, W. Liberty	R. A. Firmin, Zanesfield	1st Friday, monthly.
Marion	H. K. Mouser, Marion	J. W. Jolley, Marion	1st Tuesday, monthly.
Mercer	P. W. Fishbaugh, Mendon	F. E. Ayers, Celina	2d Thursday, monthly.
Seneca	Paul Leahy, Tiffin	R. E. Hershberger, Tiffin	3rd Thursday, monthly.
Van Wert	A. T. Rank, Van Wert	R. H. Good, Van Wert	1st Tuesday, monthly.
Wyandot	B. A. Moloney, Upper Sandusky	W. L. Naus, Upper Sandusky	1st Thursday, monthly.
Fourth District	(With Third District in Northwestern Ohio District)		
Defiance	John U. Fauster, Defiance	D. J. Slosser, Defiance	2nd Tuesday, Sept. to June
Fulton	C. F. Hartmann, Wauseon	Geo. McGuffin, Pettisville	3rd Thurs., monthly.
Henry	B. J. George, Napoleon	F. M. Harrison, Napoleon	1st Wednesday, monthly.
Lucas	M. D. Haag, Toledo	A. P. Hancuff, Toledo	Friday, each week.
Ottawa	R. A. Willett, Elmore	Cyrus R. Wood, Port Clinton	2d Thursday, monthly.
Paulding	Ray Mouser, Paulding	Gaile L. Doster, Paulding	3d Wednesday, monthly.
Putnam	W. D. Hickey, Leipsic	W. B. Light, Ottawa	1st Tuesday, monthly.
Sandusky	C. A. Kingman, Bellevue	C. J. Wehr, Bellevue	Last Thursday, monthly.
Williams	Earl Snyder, Bryan	H. R. Mayberry, Bryan	3d Thursday, monthly. Sept. to June.
Wood	F. L. Sterling, Bowling Green	R. N. Whitehead, Bowling Green	3d Thursday, monthly.
Fifth District	H. V. Paryzek, Councilor	Chrm. Com. on Arrangements	Cleveland.
Ashtabula	J. F. Docherty, Conneaut	A. M. Mills, Ashtabula	2nd Tuesday, monthly.
Cuyahoga	A. A. Jenkins, Cleveland	Clarence H. Heyman, Cleveland	3d Fri. Feb., March, May, Sept., Nov., Dec.
Erie	J. C. Kramer, Sandusky	G. A. Stimson, Sandusky	Last Thursday, monthly, except July, Aug.
Geauga	Lura E. Gordon, Burton	Isa Teed-Cramton, Burton	Last Wed. Apr. to Dec.
Huron	H. H. Ewing, Willard	J. C. Steiner, Willard	Once monthly, Feb., May, Sept. & Dec.
Lake	B. T. Church, Painesville	Mabel Pearce, Painesville	Last Tues., Monthly.
Lorain	Geo. M. Blank, Lorain	W. E. Hart, Elyria	2d Tuesday, monthly.
Medina	Harry Streett, Litchfield	J. K. Durling, Wadsworth	1st Thursday, monthly.
Trumbull	J. H. Caldwell, Warren	R. H. McCaughtry, Warren	2d Tues., monthly, Sept.-May.

Societies	President	Secretary	
Sixth District	J. D. Holston, Massillon	J. H. Seiler, Akron	2d Wed., Jan., April and Oct
Ashland	O. J. Powell, Ashland	M. J. Thomas, Jeromesville	2nd Friday, Sept. to May.
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. B. Nelson, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	Edgar H. Knowlton. Mantua	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	P. A. Stoodt, Mansfield	D. A. Weir, Mansfield	Last Thursday, monthly.
Stark	L. A. Buenman, Canton	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	R. G. Werner, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Morton, Wooster	R. C. Paul, Wooster	2d Tuesday, monthly.
Seventh District			
Belmont	C. H. Cale, Neffs	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	Seward Harris, Lisbon	Guy E. Byers, Salem	2d Tuesday, monthly.
Coshocton	Samuel Kistler, Coshocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Geo. F. Gourley, Steubenville	John Y. Bevan, Steubenville	Last Tues., monthly.
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	W. W. H. Curtiss, Dennison	Arthur Huston, Jr., Uhrichsville	2d Thursday, monthly.
Eighth District			
Athens	C. H. Creed, Athens	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	L. E. Stenger, Lancaster	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	E. F. Hunter, Cambridge	Reo Swan, Cambridge	1st and 3rd Thursday each month
Licking	Geo. H. Brown, Hebron	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3rd Tuesday, monthly.
Muskingum	M. A. Loebell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	James Miller, Corning	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	W. W. Sauer, Marietta	G. M. James, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec
Hocking	C. C. Lyon, Logan	M. H. Cherrington, Logan	Monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	Anne D. Marting, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	Hubert Thurman, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	R. J. Caton, Bucyrus	J. A. Agnew, Crestline	1st Monday, monthly.
Delaware	Harold Davis, Ashley	J. G. Parker, Delaware	1st Tuesday, monthly.
Franklin	Verne A. Dodd, Columbus	John H. Mitchell, Columbus	1st four Mondays monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
Pickaway	D. V. Courtright, Circleville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	H. C. Duke, Richwood	Angus MacIvor, Marysville	2d Tuesday, monthly.



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ALCOHOLIC TREATMENT destroys the craving for alcohol, restores the appetite and sleep, and rebuilds the patient's physical and nervous state. Whiskey withdrawn gradually. No limit on the amount necessary to prevent or relieve delirium.

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DRUG TREATMENT is one of GRADUAL REDUCTION. It relieves the constipation, restores the appetite and sleep. Withdrawal pains absent. No Hyoscine or Rapid Withdrawal methods used unless the patient desires same.

MENTAL PATIENTS have every comfort of their home.

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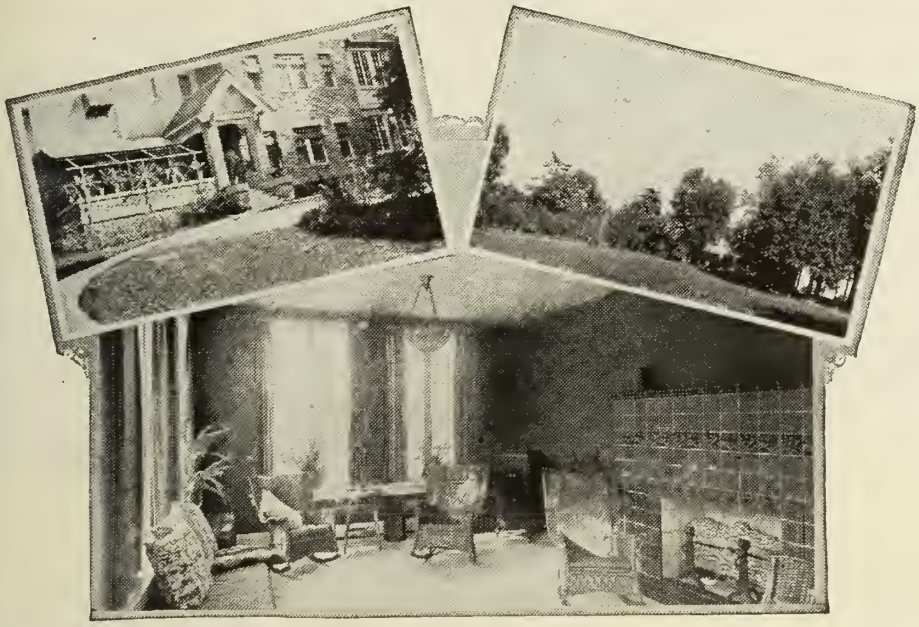


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For purely nervous cases, nutritional errors and convalescents.

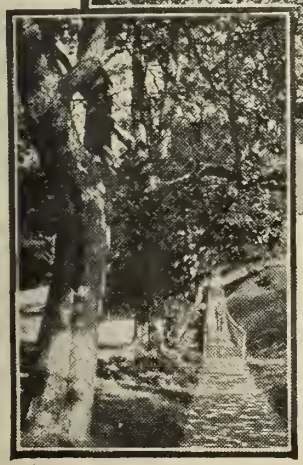
Completely equipped for hydrotherapy, massages, etc.

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Ideal surroundings for the nervous and convalescent patient.
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Even if spirochetes were localized at the site of injection the only effective portion of the antisyphilitic agent used would be the portion in solution.

Thio-Bismol is in solution *when injected . .*

Being soluble in tissue fluids it is not appreciably precipitated in the body, as many bismuth preparations are, but is promptly dispersed by the circulating blood, thus establishing a high concentration of spirocheticidal bismuth salt in the tissues.

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THIO-BISMOL (Sodium bismuth thioglycollate) contains 37.5% of metallic bismuth.

Package . . .

Boxes of 12 and 100 2-cc. ampoules (No. 156), each ampoule containing one average dose (0.2 Gm.—3 grains of THIO-BISMOL). This may be dissolved as needed in sterile distilled water, a sufficient supply of which is provided in each package.

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WITH THIS BETTER MILK FOR BABIES

★ For many years, this dependable brand of *unsweetened* evaporated milk has been helping doctors to give babies the right start in life. Their success has been due in part to the many inherent qualities of Wilson's Milk—because it closely resembles the milk from a healthy mother—is just as safe and pure—and digests more easily than raw or pasteurized milk.

And now Wilson's Milk is better than ever for babies—since it is *Irradiated* by the Steenbock Ultra-Violet Ray Process. This greatly





increases the Vitamin D content without the use of any ingredient—and it does not change any of the other qualities of the milk.

You'll be pleased with the way your babies thrive when Wilson's *Irradiated* Evaporated Milk is used in your feeding formulas. Your mothers will be pleased, too, because it is so convenient and economical to use this better milk for baby feeding.

We do not furnish feeding formulas to mothers.

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★ *All our statements about Wilson's Milk are accepted by the American Medical Association Committee on Foods.*

WILSON'S *Irradiated* EVAPORATED MILK

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Protection and *Convenience* for patients



● Drybak Adhesive Plaster offers complete security for dressings, yet causes a minimum of inconvenience. Patients can bathe or swim without worry, because the glazed back-cloth of Drybak prevents water from soaking into the plaster and impairing its strength and sticking qualities.

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THE WATERPROOF ADHESIVE PLASTER

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ESPECIALLY designed for the purpose, all Camp Sacro-iliac Supports extend well over the trochanters and sides of the pelvic bones, with a firm front section. All have two adjustments. One provides the tightness required low on the trunk; the other affords merely staying power desired above.

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Sacro-iliac Model 141

We quote from page 54 of

"The Milk Question"

by M. J. ROSENAU, Professor of Preventive Medicine and Hygiene, Harvard Medical School.

"Man has but a single stomach and this forms about twenty per cent of the digestive tract. The cow has four stomachs which form about seventy percent of the digestive tract. The calf's stomach is well fitted to handle and digest the tough, lumpy curds which form from cow's milk. Woman's milk curdles into a soft mass which is broken into numberless small particles. Evidently the stomach of the infant fed with cow's milk is over-taxed trying to break the tough curds into particles small enough for complete digestion. It is therefore evident that even if we could secure cow's milk, the chemical composition of which was exactly the same as that of human milk, it would still be far from a perfect substitute unless it behaved similarly in the digestive tract."

SIMILAC is similar to breast milk not only in composition but in digestive properties as well. Like breast milk it forms an extremely fine, soft curd of consistently zero curd tension.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

Not advertised to the laity and no directions on or in the trade package. Samples for curd tests or trial feedings, literature and recorded results of feeding with SIMILAC will be mailed on receipt of a request on your prescription blank.

SIMILAC is made from fresh skim milk (casein modified) with added lactose, salts, milk fat, and vegetable and cod liver oils.



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DIETETIC LABORATORIES, INC.,
COLUMBUS, OHIO.

WAGNER'S HAS ALWAYS AGREED

That Acidosis Requires Professional Prescribing

ACIDOSIS CLAIMS IN LAY ADVERTISING

Reprinted from The Journal of the American Medical Association, July 21, 1934

• • •

Acidosis and acid claims, and the words "acidosis," "acidity" and "acid" are frequently used in advertising to play on vague fears of the public. The usual well-balanced diet includes many alkali-yielding foods—milk in its various forms, fruits and vegetables. Acid-forming diets are not a practical nutritional problem because a good modern mixed diet adequate in minerals and vitamins can scarcely be potentially acid. It is appropriate to call attention to the fact that certain foods are potentially alkaline, or yield alkaline mineral residues in the body.

Acidosis is a medical name for a morbid condition of diminution in the reserve supply of fixed alkali in the blood and body fluids. Most people have no conception of the true meaning of the word and are quite likely to confuse it with gastric hyperacidity or "acid stomach," or to conceive of it as "acid blood," a condition which would be incompatible with life. The term "acidosis" is so little understood that its use in any advertising except that restricted to the medical profession is misleading and consequently disapproved.

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INSULIN SQUIBB IS SUPPLIED IN 5-cc. AND 10-cc. VIALS OF THE FOLLOWING STRENGTHS:

5 cc.	10 cc.
50	100 units (10 units per cc.)—Blue label
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CONSIDER the significance of this statement. For behind this product are the extensive resources of the House of Squibb. Insulin research in the Squibb Laboratories has never ceased. Many refinements in its preparation have been introduced and many additional steps in its manufacture have become routine to make the Squibb quality of Insulin possible.

Insulin Squibb is highly purified, highly stable and remarkably free from protein reaction-producing substances. Great care is taken in its assay that it may be uniformly potent.

More institutions, more physicians, more patients are using Squibb Insulin than ever before. For these users are convinced of the quality and dependability of the Squibb Product.

INSULIN SQUIBB

THIS YOUNG MOTHER IS ABOUT TO MAKE A MISTAKE



THIS mother went to her doctor to get an infant feeding formula. The doctor wrote the formula —using evaporated milk as the chief ingredient—and sent the mother on her way with a friendly warning —"Follow these instructions to the letter!"

But . . . those instructions were just *seven letters* short!

Seven letters, B-O-R-D-E-N-S.

To the physician, the name Borden has so long been synonymous with pure, high quality evaporated milk that he is likely to take it for granted that all mothers would choose as he would. How much better it is to make this wise choice a certainty! One word—Borden's—in the infant feeding formulas you write will make sure that your little patients get an evaporated milk that measures up to your highest professional standards.

Borden's Evaporated Milk was the first evaporated milk for infant feeding to be submitted to the American Medical Association Committee on Foods, and the first to receive the seal of acceptance. No formulas are given to the laity . . . Free to physicians—full-sized cans of Borden's Evaporated Milk. Just write to The Borden Company, Dept. OH 94, 350 Madison Ave., New York, N. Y.

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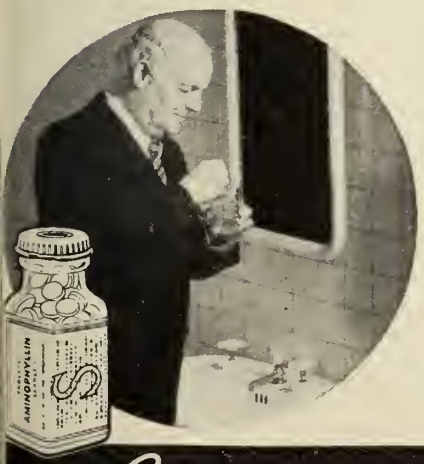
Valuable Prophylaxis in Angina Pectoris and Coronary Disease

In cardiac conditions associated with pain, Aminophyllin (Searle) offers the physician a two-fold desideratum: parenterally administered, it tends to terminate the seizure and to relieve the devastating pain of the acute attack; when administered orally (in tablet form) over a prolonged period, it tends to exert a valuable prophylactic influence. In some cases it obviates further attacks entirely; in others it lessens the frequency of such seizures as do occur, and reduces their severity.

The anginal patient, generally speaking, readily responds to this prophylactic influence. His fear of further attacks is removed, confidence returns, and with it renewed efficiency in his daily pursuits.

Aminophyllin (Searle)—cold water soluble theophylline-ethylenediamine—is the original American product of its kind. It has brought this valuable therapy—formerly available only at much higher prices—within the reach of every anginal patient.

A monograph on the rational drug treatment of cardiac conditions associated with pain will be mailed to physicians on request.



G. D. Searle & Co.

FINE PHARMACEUTICALS SINCE 1888

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Aminophyllin (Searle)

COUNCIL ACCEPTED

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Makers of Medicinal Products

EPHEDRINE INHALANTS

Lilly

Ephedrine shrinks the nasal mucous membrane and stimulates ciliary action. It reduces congestion, improves nasal respiration, and helps to maintain the sinus openings and promote drainage. The action of ephedrine is prompt and well sustained. Daily use over a prolonged period does not usually alter the rapidity or duration of action.

Inhalant Ephedrine Compound, Lilly, contains ephedrine 1 percent, with menthol, camphor, and oil of thyme, in a neutral paraffin oil.

Inhalant Ephedrine (Plain), Lilly, contains ephedrine (in the form of ephedrine cinnamic aldehyde and ephedrine benzaldehyde) 1 percent, in an aromatized paraffin oil.

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

In this issue of *The Journal* will be found the official program for the 88th Annual Meeting of the Ohio State Medical Association to be held Thursday, Friday and Saturday, October 4, 5 and 6, at the Neil House, Columbus, and other information concerning the Annual Meeting, including a list of Columbus hotels, their rates and facilities and the annual golf tournament to be held Wednesday, October 3, at the Columbus Country Club.

Annual Meeting Program

Every member is respectfully requested to study the program for the Columbus meeting carefully. Special effort has been made by the Council Program Committee to formulate a well-balanced as well as interesting program of papers and discussions. It will be noted that several new features have been scheduled, chief of which is the plan of having a number of the lectures supplemented with clinical demonstrations.

Special attention is called to the fact that the meeting this year will last two and one-half days, extending through Saturday morning, October 6. This will permit each scientific section to hold two sessions, one on Thursday afternoon, October 4, and one on Saturday morning, October 6.

The annual addresses of the President and President-elect will be presented on Thursday evening, October 4, at a general session. A banquet sponsored by the Columbus Academy of Medicine will be held on Friday evening.

A detailed analysis of the program is unnecessary since it speaks for itself. Every effort has been made to schedule speakers and discussants especially qualified to talk on the subjects selected for both the general and section meetings. Papers will have an appeal to both general practitioners and specialists. The time schedule for lectures will be followed as closely as possible, to avoid delays and conflicts.

Additional information concerning the Annual Meeting will be published in the October issue of *The Journal* which will contain the annual reports of the standing and special committees of the State Association, and which will go to press earlier than usual so that each member will have a copy well in advance of the opening day of the Columbus meeting.

Each member should resolve now to read and study the annual reports of the various committees. They are in effect historical accounts of the activities of the State Association during the past year. Moreover, they present critical analyses of many of the important economic, social, governmental and organization questions which confront the medical profession at the present time and offer suggestions and procedure in meeting these questions.

— OSMJ —

During the long period of business adversity and social unrest, the medical profession, individually and collectively, has taken many a hard knock.

Bouquet Gratefully Received

The profession has suffered financially. It has been subjected to scathing attacks by reformers and busy-bodies. At times it has seemed as if the public in general has been unappreciative of the meritorious and faithful services the profession has performed.

Nevertheless, the profession has played the game. It hasn't fallen down on the job or shifted its responsibilities. It has driven hard and straight toward its goal of improving the standards of scientific medicine and seeing that the public gets the benefits of those advances. The traditional and humanitarian principles which have for centuries been the keystone of medical practice have been preserved. The profession cannot be accused of playing the role of sob-sister or quitter. All it has demanded is fair play and justice in return for its efforts.

Too frequently, thoughtless individuals and those with selfish motives have resented and even criticized the profession for asking that its services be appreciated and that physicians be given an even break with others administering to the needs of society.

Fortunately, however, some expression of appreciation or comment championing the cause of the profession is forthcoming, dispensing light among the gloom and giving the profession some cause to believe that at heart the public is not willing to see such public service destroyed or crippled.

An example is the following editorial comment published recently by the *Cleveland News* which,

although it deals with the financial side of medical practice, contains much wholesome philosophy and illustrates the type of welcomed publicity which builds up rather than destroys public confidence in scientific medicine and the medical profession. To quote:

"A health journal devotes a page to discussing the question of why the doctor's bill is always the last to be paid.

"It shows a picture of a typical American family going over its accounts at the end of the month, calling its budget balanced because all of its bills "except the doctor's" will fit in.

"The depression has served, as nothing else, to stress the prime injustice of making the doctor take it coming and going when times are hard and money is scarce.

"The doctor's services are needed just as much in bad times as in good, and are as cheerfully rendered.

"The doctor, in justice to humanity and the dictates of his high calling, cannot refuse to be of aid when needed. Yet in hard times he must suffer the loss of returns on his own investments, perhaps go through a bank failure or two, and assume other people's financial burden on top of his own by carrying the majority of his patients 'on the books.'

"The doctor can't take away the baby because the installments cease to be paid. He can't foreclose on our families, or shove us back into our previous state of bad health because we are unable, or refuse, to pay him. He can't put a cash and carry sign over his door.

"He wouldn't if he could. His philosophy is all against it.

"His life story is one of service, of making other people happy, no matter how down in the mouth he may feel himself. He must be a good actor when he approaches his patient, especially the very young patient who so often needs him. He must 'sell' health and recovery and the principles of right living.

"Yet at heart he is neither an actor nor a salesman.

"The world knows him for a kindly, sympathetic, unselfish human being, working day and night, who sees so much of suffering that he enjoys the thrill of the true craftsman in seeing his efforts yield results in health and happiness.

"Each of us would consider himself very shabbily used if the doctor would turn to our aid only after he had seen to everything else that had a claim on him. Yet all too often we let the doctor worry about his taxes, his rent, his car, his light and gas and telephone bills and the expenses of his office while we take care of those obligations which most urgently and disagreeably press us.

"Let's try paying the doctor first for a while—he can endure the shock.

"Let's budget our household expenses so as to provide in advance a modicum of income for health emergencies and make the doctor as happy as we are when he has done his part and helped put us on our feet, save our lives and our jobs.

"It isn't fair to penalize our best friend for our own failure to install the right kind of home bookkeeping, even though we have become used to it."

Social And Scientific

One of the over-worked charges of those who have an overwhelming desire to tear apart and reconstruct the present system of medical practice is that present-day medical service is failing to meet public needs because the social side of medicine is lagging behind the scientific progress in medicine and that medical service will not reach its zenith until this situation is remedied.

We are not convinced that whatever lag there has been on the part of the social aspects of medical service in comparison with the advances of scientific medicine has not been in the best interests of society.

After analyzing some of the remedies which have been suggested to advance the social side of medicine, one is forced to wonder if they would not create situations many times more alarming than the one they are supposed to correct.

As a matter of fact, there is grave doubt that the social side of medicine has not made advances comparable to those made in scientific medicine and that those which have already been accomplished, and will be made in the future, along conservative lines and under medical guidance, have not satisfactorily met the needs of the public.

Logical thinkers do not ignore nor have they failed to realize the steady but unpretentious progress which has been recorded in methods of providing society with the benefits of research and experiments in the medical sciences.

For example, Merle Thorpe in answer to those who charge that "we have over-developed the material and neglected the spiritual side of life; made magnificent strides in science but have lagged in philosophy", cites the case of medicine to refute this indictment.

Putting critics of the existing order on the spot, Mr. Thorpe, writing in *Nation's Business*, declared:

"Haven't we advanced the social side of medicine as fast as we have advanced its physical side? Is not the tremendous growth of hospital facilities in the last two decades an indication that our social machinery has been advanced?

"We have developed the automobile but does man drive it solely to see how fast he can make it go? To tens of thousands of families the automobile has laid open new beauties of nature.

"Take the growth of our school population. In 1930 there were 31,500,000 children between five and seventeen in the United States and 30,000,000 of them were in school, about 95 per cent. In 1870 the percentage was less than 60 per cent. Child labor was on its way to oblivion before 1933. Was not that advancement in our social machinery?

"The fact is that we have made tremendous social advances without thinking of them as social. And they have been made under a capitalistic system and a large part of the advance has been due to the individual wisely using the profits he had made in industry. Nicholas Murray But-

ler, president of Columbia, speaks of rendering public service 'in the field of Liberty' and adds:

" 'Non-profit making institutions of every sort and kind were brought into existence in the field of Liberty to render public service . . . They included hospitals and homes for aged, the infirm and the dependent. They included libraries and museums, some of which have now gained world-wide reputation and influence. They included a host of schools and colleges, and in these later years at least a dozen or more universities, all of which have united to give to the American people a high and distinguished place in the intellectual life of the modern world. These institutions are in no sense governmental, but they are in every sense public.'

"No thinking man can escape asking himself this question:

"Will our social, our political, our economic machinery advance faster under governmental direction than through this public service in the field of Liberty?"

Perhaps most of those who believe in constitutional individualism and opportunity will answer in the negative.

The odds are overwhelmingly against advancement in both the social and scientific aspects of medicine under political and bureaucratic dictation and direction.

Gradual, wholesome and necessary progress has been made, and will continue to be made, under professional control and through individual effort, initiative and enterprise.

— OSMJ —

Ambitious Osteopaths

Perhaps the fact that this is open season for platforms, planks, slates, declarations, etc., was the incentive which prompted the publication in a recent issue of *The Buckeye Osteopath*, official monthly bulletin of the Ohio Society of Osteopathic Physicians and Surgeons, of a list of objectives of that organization for the ensuing year:

Under the heading, "Nuts to Crack", were listed the following matters on which the activities of the osteopathic society will center during the forthcoming months:

"1. Independent osteopathic examining board.

"2. Osteopathic representation on the staff of every public supported hospital.

"3. An osteopathic unit in every county hospital of sufficient size to warrant an allotment of patients in the ratio of twenty to one, or according to the existing ration between the number of physicians representing the drug and osteopathic schools.

"4. Facilities for the training of osteopathic interns in hospitals supported by public funds.

"5. Osteopathic representation on health boards.

"6. Osteopathic treatment to be made available for the treatment of inmates of every state and county institution for the the insane.

"7. The right to qualify for positions in city, state and federal government, and for commissions in army and naval service now denied to all physicians not graduates of the drug school.

"8. The right to qualify for advanced rating in tax-supported colleges upon the submission of proof of osteopathic training, or by fair examination in subjects taught in osteopathic colleges."

Judging by this ambitious platform of desires and demands, osteopaths who realize the actual limitations of osteopothic practice and would like to become full-fledged doctors of medicine through some kind of legislative hokus-pokus are going to make things lively in the near future. They've already put their "educational pressure" on candidates and public officials.

Incidentally why does the "Nuts to Crack" editor draw such a careful distinction between "the drug and osteopathic schools" when their real desire is to practice general medicine on a meager educational foundation and on a now discarded anti-drug theory?

In these days of radical changes, even such a ridiculous program as that promoted by the osteopaths may gain a surprising amount of support.

— OSMJ —

Principles And Traditions

During one of the hectic sessions of the now deceased 73rd Congress when an important piece of financial legislation was being debated on the floor of the United States Senate, Carter Glass, the experienced Senator from Virginia, took the floor to oppose provisions of the measure that he considered filled with potential danger and destruction. In the course of his remarks he declared:

"Bacon, the wisest philosopher since Christ, the author of the inductive system from which we have drawn all of our inventions, valued experience. Edmund Burke, the greatest rhetorician of all time, was logician enough to magnify experience. Patrick Henry, the great advocate of human liberty, said that his feet were lighted by the lamp of experience. Yet, here today, we are flying right in the face of experience, rejecting it all."

We recommend a careful reading of this classical warning of the Senator from Virginia to those who are intent upon bringing about a social reformation based on programs and theories that have never been measured by the yard-stick of experience or have been found fallacious when so measured. More specifically, we recommend Senator Glass's admonition to those who are determined to destroy the present system of medical

practice and substitute for it a bureaucratic and socialized plan, featured by political control and regimentation.

Secondly, we recommend that the above quotation be carefully read by those members of the medical profession who refuse to heed the warnings arising from present under-currents and trends and still are naive enough to believe that the interests of the medical profession will be protected by those who are long on promises but short on sincerity without a battle on the part of the profession itself.

Experience has proven only too conclusively that every time the medical profession has adopted an attitude of compromise or defeatism, and has gullibly placed its faith in those of doubtful allegiance and questionable integrity, medicine and the medical profession has suffered.

The medical profession must learn well the lessons of its own experience. Unless it does this and promptly realizes that principles and traditions worth preserving are worth fighting for, it will find itself eating the crumbs that fall from the table of demagogues and theorists.

— OSMJ —

Vast Debt

"The more one studies the national and state situations, the more they disclose the need of reduction in public expenditures; the control of debt; and the absolute necessity of teamwork among thinking, cooperative, patriotic citizens to bring the necessary reforms about," states a recent bulletin issued by the Ohio Inter-Organization Tax Association.

According to statistics cited in the bulletin, the total national taxes collected in Ohio in 1933 amounted to $98,185,511. The current tax levies in Ohio for 1933 amounted to $201,345,548. The tax duplicate of Ohio in 1933 was $8,781,468,840, while in 1930 it was $13,452,946,926, "showing the necessity for economy". Delinquent taxes and assessments in Ohio in 1930 amounted to $101,283,098, while in 1933 this amount had increased to $201,345,548. The total debt, national, state and local now amounts to more than $45,000,000,000 and "is constantly increasing; this is a debt loan of approximately $350 for each man, woman and child in the United States".

Additional figures on bonded indebtedness, borrowings, etc., are given to show that a hopeless situation is in the offing unless prompt reduction is made in public expenditures and public functions.

Since physicians can qualify as "thinking, cooperative, patriotic citizens", and as a group have a larger financial stake in the costs of government than some other classes of citizens, it behooves them to do some serious thinking about public matters generally.

With the general election approaching, physicians should consider the serious question of public debt and taxation as well as governmental policies and functions in connection with the qualifications and platforms of various candidates for public office. Public expenditures will not be reduced materially, with resultant relief for the taxpayers, accompanied by preservation of constitutional government until sufficient public opinion is mustered to express, by ballot, such mandate.

— OSMJ —

Practice In Radiology

Writing in the publication, *Radiology*, Dr. Robert R. Newell discusses the growing tendency on the part of a minority of the medical profession to make too frequent use of non-medical technicians in providing their patients with the benefits of this increasingly important phase of medical practice.

Every physician well realizes the necessity for a thorough medical training in all diagnostic and therapeutic procedure. Roentgenology is no exception to this principle. However, as Dr. Newell points out, some physicians apparently are not so convinced and refer their patients to non-medical technicians for radiography instead of to trained and competent medical radiologists.

"The industrial arts are now seen to be using *X*-rays and radium more and more in inspection of welds, and the gross and fine structure of materials and finished products," Dr. Newell declares.

"It would seem an obvious parallel to the medical ideal, that such inspection service can be best given by a broadly trained engineer specializing in radiology. To do intelligent radiography of materials one might need as keen an insight into their structure and use as one needs of anatomy and physiology to do intelligent radiography of man.

"It would appear, therefore, that a physician radiologist who, because he has an *X*-ray machine undertakes to do industrial roentgen inspection, is in somewhat the same position as a lay radiographer making roentgenograms of human patients."

Dr. Newell draws these conclusions which may receive sympathetic consideration from all physicians, including the specialist in radiology:

1. Physicians should refer their patients for roentgen diagnosis and therapeutics only to medical radiologists.

2. Medical radiologists should deserve this by being, as much as possible, well-trained and broad-thinking physicians and not merely narrow technical specialists.

3. To the trained engineer specializing in radiology should be left the work of using radiography in industry.

THE TOXEMIAS OF EARLY PREGNANCY

By WM. D. FULLERTON, M.D., F.A.C.S.,

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THE great majority of pregnancies progress along a normal physiological course, with slight, if any, untoward symptoms. However, the division between normal and abnormal physiological function is extremely narrow, and only slight irregularities of the normal, may very suddenly change the state to one distinctly pathological.

I am thoroughly in accord with Williams, that although we must as yet admit our profound ignorance as to the etiological factors in the toxemias of pregnancy, these toxemias are better studied separately, and are not to be considered as due to one and the same cause.

Clinical symptoms, such as nausea, albuminuria, fever, coma, convulsions, and so forth, may be caused by totally different pathological conditions, but constant and distinctive pathological lesions are associated with certain of the toxemias, which strongly suggests a difference in the etiological factors.

Toxemia is indeed a very broad term, and properly refers to any poisoning by toxins, produced by or within the body cells, by microorganisms, or by disturbances in metabolism. Any of the innumerable conditions which result from such causes may occur in the pregnant woman, but common usage and understanding is that toxemias of pregnancy are only such conditions as are intimately related to and associated with the pregnancy.

This reduces the list of conditions for our immediate consideration, which is further shortened by discussing only such conditions as are usually associated with the first third or first half of pregnancy. Of these we may briefly mention ectopic pregnancy, abortions, the presumable toxemias, and then more fully discuss acute yellow atrophy, vomiting and the nephroses.

ECTOPIC PREGNANCY

In about one in every 150 women who become pregnant, the ovum remains in the tube, and of these, not over 50 per cent are ever recognized. Many causes for this tubal arrest have been suggested — mechanical, developmental, inflammatory—as well as abnormal decidual formation in the tube. The formation of decidua is dependent upon the normal interaction of the endocrine glands, as affected by the fertilized ovum. May not a toxemia, in the broad sense of the term, be responsible for an endocrine dysfunction, and play a part in the etiology of extrauterine pregnancy?

We are considerably concerned in differentiating this condition with its endocrine reaction, localized peritonitis, nausea and vomiting, bleeding, rupture, infection, shock, and so forth, from other more commonly classified toxemias.

ABORTION

One out of every three pregnancies ends in abortion, of which at least one-third are induced. Abortion is a foremost cause of hospitalization of women, and the mortality is six times that for normal labor, accounting directly or indirectly for 75,000 deaths in the United States every year.

About half of all spontaneous abortions are due to fetal death, and 60 per cent occur within the first three months. Up to six weeks, defects in implantation, and from six to twelve weeks, defects of placental formation, are chiefly responsible for abortion. Embryological defects, trauma, drugs, and so forth, are responsible for many abortions, but autointoxication, infections, nutritive disturbances, deficiency in vitamins, disturbed metabolism, alterations in endocrine and biological factors may, through the toxemias they produce, be held responsible for a vast number of abortions.

It seems to me most appropriate, that when toxemias are under discussion, those mentioned above be given due consideration. Although they are rarely directly fatal to the mother, they are indirectly responsible for many deaths from the sequellae of abortions, and are the cause of a great deal of unhappiness.

PRESUMABLE TOXEMIAS

We occasionally see certain conditions in pregnant women, with or without other symptoms, the cause of which are unknown, but perhaps are best explained upon a toxic basis, the result of autointoxication, disturbed metabolism, endocrine dysfunction, or allergic reactions.

I refer to certain psychoses, some of which may accompany pre-eclamptic toxemia with its usual symptoms, to others without any discoverable maternal symptoms, which usually clear up with rest, milk diet, and eliminative measures. In the psychoses, as well as in peripheral neuritis, some source of infection should always be carefully sought. Certain skin conditions, such as impetigo and herpes, may resist any and all treatment, but rapidly disappear when the pregnancy has terminated. Excessive salivation, urticaria, and asthma, without other symptoms or findings, may be most troublesome, resist all

*Read before the section on Gynecology and Obstetrics of the Cleveland Academy of Medicine, January 24, 1934.

treatment, and then clear up almost instantly when the pregnancy has ended.

ACUTE YELLOW ATROPHY

In 1706, Kerkring first described this condition during pregnancy. This complication is rare, but is very serious. About 60 per cent of all cases occur in pregnant women. It may appear at any time, has been described as early as the sixth week, but is more usual in the latter months and even the puerperium.

The onset may be chronic, but it is often acute. There are often abdominal pains, severe headache, and frequently nausea, vomiting and diarrhea. The woman becomes torpid or delirious, then comatose, and many have convulsions, in which case the condition is frequently confused with eclampsia. There is a varying degree of jaundice, the liver is reduced in size, the stools are often clay colored, the urine contains albumin and casts, and often blood. The ammonia nitrogen of the urine is greatly increased, the blood sugar is reduced. Titus has considered and called the condition an "acute fulminating hypoglycaemia". The pathological lesions are quite similar to those of phosphorus and chloroform poisoning, and of toxic vomiting of pregnancy.

These changes must be considered as secondary to a profound toxemia, the cause of which is unknown, but producing a wide-spread autolytic necrosis of the liver. The treatment should be similar to that to be outlined for toxic vomiting, except that if rapid improvement is not seen, the uterus should be emptied without delay by whatever means is least shocking to the patient, and the anesthetic used, if any, should always be spinal.

NAUSEA AND VOMITING—HYPEREMESIS GRAVIDARUM

Certainly 75 per cent of all pregnant women have more or less nausea or vomiting, or both, during their early pregnancy. This nausea usually begins about the sixth week, but may occur before a period has been missed. Its average duration is about ten weeks, though it may persist even to term. In the great majority of these women the condition is not serious, but they may be made much more comfortable by appropriate measures.

Vomiting during pregnancy has been divided into three types, neurotic, reflex, and pernicious or toxic. The first two types are rarely serious, but either may, if prolonged and severe, progress to the pernicious type.

The so-called neurotic or psychic type is more often seen in nervous, high-strung women of the upper classes, who greatly desire a pregnancy or who resent their condition, and in those who crave sympathy. Fear and selfishness are important factors, and not infrequently a woman uses such means deliberately to impress her physician when seeking abortion. A careful inquiry into the patient's general makeup and mental attitude, will usually suffice to differentiate this type, and appropriate psychological suggestions and assurances will affect a rapid cure.

The truly reflex type of vomiting is not common, but an incarcerated retroverted uterus, fibroid or ovarian tumor, or local lesions of the generative tract, will occasionally be accompanied by considerable vomiting, which is quickly relieved when the abnormal condition is corrected.

True toxic or pernicious vomiting which is progressive, is not common, but if not seen until advanced, is indeed a serious complication of pregnancy. It is quite probable that all vomiting for which the pregnancy is responsible, is due to the same factor, the severity of the condition varying with the reaction of the individual to this factor. The condition is definitely associated with a pregnancy and a living fetus, for, with termination of the pregnancy or death of the fetus, the condition, unless already too advanced, very quickly improves. However, let me state emphatically at this point, that such drastic action as therapeutic abortion is very rarely, if ever indicated, in view of the excellent results of modern treatment, based upon our present knowledge of the physiological aspects of this condition.

The primary cause of the known physiological disarrangement is unknown, but it is of much interest that the symptoms begin at the time the fetal elements reach some appreciable proportion. Knowing that fetal cells are half paternal in origin and protein in nature, raises the question whether or not the woman may be hypersensitive to this paternal protein, and react in proportion to her hypersensitiveness. The usual disappearance of her symptoms after some weeks, may be accounted for by an acquired immunity to such protein.

In 1896, Veit held that all disturbances of pregnancy result from cytolitic processes following entrance of chorionic tissue and fetal ectoderm into the maternal circulation.

There is also the possibility that the vomiting is initiated by some product of fetal metabolism, protein in nature and as yet unknown. Some investigative work has been started upon these hypotheses and I hope to be able to report the results at a later date.

Many women are on diets which furnish just enough carbohydrates to maintain their carbohydrate balance. They become pregnant. Pregnancy is known to cause a carbohydrate drain. Their carbohydrate reserve drops, they are nauseated, their appetite is lost, they fail to eat sufficient foodstuffs, their blood sugar continues to decrease, they vomit, cannot retain what they do eat, become progressively dehydrated, and with a falling sugar reserve, are soon in a vicious circle. There being then insufficient sugar for

normal metabolism, the fats of the body are called upon, and they being incompletely broken down, due to insufficient sugar, which is essential to the complete oxidation of fat, the ketone bodies in the blood increase, there is insufficient alkali present, and an acidosis results with diacetic acid and acetone in the urine, and an acetone odor on the breath. The loss of hydrochloric acid by vomiting may exceed the alkali deficit, and an alkalosis result. Therefore, an alkali reserve estimation should be made in all severe cases.

The pathological lesions found at autopsy, show a necrosis of the liver cells around the central vein of the lobule, and a fatty degeneration beyond this, which may include almost all of the liver tissue. The kidneys show degenerative changes which are chiefly of the convoluted tubules.

Whether the vomiting is inaugurated by some unknown factor, and the deficiency in carbohydrate reserve follows, or whether this deficiency is primary, and the vomiting secondary, may be debated, but the clinical picture and treatment of the condition are the same and well established. Bearing in mind at all times the underlying physiological aspects of the condition, and that a carbohydrate deficiency is the chief underlying factor, cause or effect, in nausea and vomiting, the treatment should be directed accordingly.

Ambulatory or residential cases will be made much more comfortable, and a more serious condition usually avoided, by the following regime:

TREATMENT OF MILD CASES

1. Hard or sweetened dry crackers on waking in the morning, half an hour before rising.
2. Frequent (6 or 7) small meals during the day, rich in carbohydrates, sugars, sweets, syrup.
3. A piece or two of candy, cake chocolate or lump sugar, every hour or two during the day.
4. Sedatives if necessary. Effervescent triple bromides, 20 to 30 grains, two or three times daily. Amytal in 3-grain doses, if sleepless. Sometimes a capsule containing 2 grains of pepsin, ¼ grain silver nitrate, and 5 grains of cerium oxylate, taken before meals, three times daily, is helpful.
5. Rest is most essential, both physical and mental. Domestic and social obligations should be eliminated so far as is possible, and an hour's rest in bed every afternoon is of great advantage.
6. The psychological aspects of the case should be carefully studied, and appropriate psychotherapy with every reassurance and consideration will be most helpful.

TREATMENT OF SEVERE CASES

If the symptoms are progressive, or the woman is not seen until she is extremely and seriously ill, the following routine is advocated.

1. Hospitalization. She should be placed in a quiet, darkened room, absolutely no visitors allowed, and be disturbed as little as possible.

Two hundred cubic centimeters of blood withdrawn immediately for the following estimations. Blood sugar, non-protein nitrogen, urea nitrogen, uric acid, carbon dioxide combining power and the H-ion concentration, and also the usual blood cell counts.

A catheterized specimen of urine examined for quantitative albumin, casts and sugar.

Absolutely nothing to be given by mouth until ordered.

2. Sedatives: Thirty grains of chloral hydrate and 40 grains of triple bromides, in milk or normal saline, by rectum. This, or the equivalent sedatives, in such doses as are found necessary to keep the patient quiet, and to be repeated every six hours and continued until all vomiting has stopped, and then gradually withdrawn.

3. Intravenous glucose, 300 c.c. of a 25 per cent solution of chemically pure glucose, (75 grams) in freshly double distilled water, to be given intravenously every eight to twelve hours, and continued until sufficient mouth feeding can be resumed.

These injections should be given slowly, not over 3 c.c. per minute. If given too rapidly, the glucose will be eliminated by the kidney and the dehydration increased.

Commercially prepared glucose can now be had in ampoules, but if it is secured elsewhere, great care is essential in its preparation to avoid unpleasant reactions. Let me refer you to the work of Titus et al. (Amer. Jour. Obs. & Gyn., 1927, 14, 181) for the method of preparation.

If adequate laboratory facilities are at hand, daily blood sugar estimations should be done and the glucose injections continued, though possibly reduced in amount, until the blood sugar is normal for several days and mouth feeding resumed. Without this laboratory aid, the injections should be continued until the urine is acetone free, and a glycosuria occurs after each injection.

Excepting in diabetes, the use of insulin is contra-indicated. The normal pancreas will respond to the glucose injections and produce sufficient insulin. Any addition to this may amount to an overdose of insulin with detrimental effects.

4. Dehydration: All of these women vomiting freely are dehydrated, and it is of the greatest importance that this condition be corrected. At least 2500 c.c. of fluid in the form of normal saline, is to be given daily. This amount may be doubled with benefit if the patient's condition warrants. The saline may be given partly intravenously, slowly, 3 to 5 c.c. per minute, and partly by hypodermoclysis. Rectal administration is not recommended so long as sedatives are given by this route.

5. Acidosis and Alkalosis: If, as already discussed, the ketone bodies are present in the blood in excessive amounts, an acidosis results. This will usually be quickly corrected when an adequate supply of glucose is furnished, as the glu-

cose will largely replace the fat metabolism, and furnish a sufficient supply of Co_2 for complete oxidation of the fat which is utilized.

When the acidosis persists, that is, if the ph or H-ion concentration is much below 7.6, or the Co_2 combining power much below 40, 50 to 75 c.c. of a soda bicarbonate, 3 to 5 per cent solution in tap water, may be given per rectum twice daily.

Occasionally in prolonged and severe vomiting, alkalosis is present, that is, there is an excess of buffer alkali in the body, in which case the ph is above 7.6 and the Co_2 above 70. In such cases, 3 c.c. of dilute hydrochloric acid, or 45 grains of acid sodium phosphate, in 50 c.c. of tap water, may be given rectally twice daily, and controlled by daily blood readings.

Usually within one to four days the vomiting has ceased and the blood sugar returned to normal. We may now allow sweetened fruit juices and tea or coffee by mouth, in 1 or 2 dram amounts every fifteen minutes, and when the patient can retain 800 to 1000 c.c. of these a day, we discontinue the intravenous glucose and start fractional feedings of solid foods, rich in carbohydrates and proteins, and increase them rapidly.

The patient should stay in the hospital for several days on a diet of solid foods with an adequate fluid intake, before going home. The sedatives are given by mouth in such doses only as necessary, and withdrawn as soon as possible.

Directions for her routine at home: a diet rich in carbohydrates, adequate fluids, rest, care of bowels, and psychotherapy if needed, will enable the woman to continue her pregnancy, in the great majority of cases without further undue discomfort.

NEPHROSES

The nephroses which complicate pregnancy, or are complicated by pregnancy, are more usually of greatest importance in the last trimester. However, in the matter of prognosis, such conditions are of vital importance in the first trimester.

Stander and Peckham, (Amer. Jour. Obs. & Gyn., 1926, 11, 583), have made a most excellent classification of the late toxemias of pregnancy, and have very clearly described and differentiated the part played by the kidneys. I would refer you all to this excellent discussion.

Without going into detail, this classification is as follows:

1. Eclampsia; 2. Pre-eclampsia; 3. Chronic nephritis complicating pregnancy; 4. Eclampsia superimposed upon nephritis; 5. Low kidney reserve.

This paper is not concerned with groups 1 or 2, so we will refer to them only in comparison with the remaining groups.

CHRONIC NEPHRITIS

In women with this condition, the history is of great importance, as is a most careful physical and clinical examination. This condition is more common in the latter years of the childbearing period, and bears a definite relationship to multiparity, being more severe in each successive pregnancy. Only about 10 per cent of these nephritics have cardiac complications. An hypertension, even without other signs of nephritis, such as albuminuria, oedema and lowered kidney function, is of great prognostic importance.

The history of the nephritic will show an increasing severity of symptoms, occurring at an earlier date, in each successive pregnancy. A rising blood pressure, oedema, and albuminuria occur earlier than in eclampsia. The oedema and albuminuria are more persistent, though less marked, and the return to normal of the blood pressure, and particularly the diastolic pressure, is much slower in the nephritic puerperium than after eclampsia.

The nitrogen partition in the urine is often disturbed, the ammonia nitrogen increases, and the urea nitrogen is relatively less in amount. Nitrogen retention in the blood is often seen of both non-protein and urea origin.

Convulsions and coma are slower to appear and less frequent and severe in nephritis than in eclampsia. Examination of the eyegrounds may show an albuminuric retinitis and arteriosclerosis, oedema or hemorrhage of the retina. The two first conditions are not found in eclampsia. The phenolsulphonephthalein functional test for the kidney is of little value in any of these toxemias.

Clinically, it may be impossible to differentiate chronic nephritis and eclampsia when the symptoms are more advanced, and it is well to defer a diagnosis until late in the puerperium, when the subsequent course will be most helpful.

Although a small percentage of pre-eclamptics later develop chronic nephritis, eclampsia is not a contraindication to subsequent pregnancies. On the other hand, each subsequent pregnancy in a nephritic, unquestionably accentuates the disease and greatly shortens the woman's life expectancy. In a series of such cases, the ten-year mortality was 42.5 per cent, compared to 7.5 per cent for women between 30 and 40 years of age.

The time to prevent further damage to an already impaired kidney is early in the pregnancy, and I advocate an early termination of the pregnancy, preferably with sterilization, as soon as the clinical symptoms are definite or when the history of past pregnancies is accurate and conclusive.

Eclampsia superimposed upon Chronic Nephritis:

Under this heading, suffice it to say very briefly, that eclampsia may occur in a woman with chronic nephritis. We are of this opinion, due to the fact that some 10 per cent of women having convulsions, have some permanent renal

impairment, similar to that found in chronic nephritis.

The symptoms in these cases are usually more severe than with either condition alone. The amount of albumin in the urine is greater, the blood pressure higher, and remains so following delivery. The eyegrounds show evidences of chronic nephritis.

These cases should be treated prophylactically, exactly as are chronic nephritics.

Low Kidney Reserve:

This condition usually appears late in pregnancy when the kidney reserve is unable to meet the extra demands of pregnancy. At all other times the kidney function seems to be perfectly normal.

These cases are most important from the standpoint of diagnosis and prognosis, as grave mistakes may be made in both of these respects, and great injustice done.

The principal findings in patients with a low kidney reserve, are an elevated blood pressure, which is rarely over 150 m.m. systolic, and with only a corresponding rise of the diastolic pressure, both of which return to normal by the end of the puerperium. The amount of albumin in the urine is relatively low, usually less than one gram per litre, and this usually disappears shortly after delivery. Oedema, if present, is slight and disappears quickly, no abnormalities are found in the chemistry of blood or urine. Headaches are uncommon, and the eyegrounds are normal.

This condition, found alike in both old and young, primipara and multipara, is not accentuated in subsequent pregnancies, in fact, is often less severe or absent entirely. There is no evidence of permanent kidney damage.

In conclusion then, we need feel no alarm concerning the outcome in patients with a low kidney reserve, and can give them every assurance as to the safety of future pregnancies.

1508 KEITH BUILDING.

DIVERTICULOSIS

Diverticula of the Alimentary Canal, Especially of the Sigmoid Colon and Their Manifestations

By E. H. CHAPIN, M.D., F.A.C.S.,
COLUMBUS, OHIO

DIVERTICULA are abnormal blind ending protrusions from an organ or viscus of the human body. They are not uncommon and may arise from any portion of the alimentary tract (pharynx, esophagus, stomach, or intestines) from the mouth to the rectum.

The condition was recognized as early as two and one-half centuries ago. According to Boyd,[1] reference was made to sacculations of the duodenum in 1710. A German anatomist, Johann Frederick Meckel described a congenital type of diverticulum of the ileum in 1808 which bears his name. Forty years later (1840) a French anatomist and pathologist named Cruveilhier mentioned the existence of diverticula of the colon which was followed by added descriptions by Virchow (1853) Habershon (1857) and Sydney Jones (1858).

Although from henceforth cases were frequently reported in many medical periodicals published both in this country and abroad, the subject did not receive the attention it deserved until the last quarter century. Regardless of the fact that laboratory, postmortem, and experimental studies have been many and the literature is voluminous, the medical profession is not adequately informed in regard to its importance as a pathological entity. The foregoing statement is proved in the fact that few cases are diagnosed before being referred for treatment. Often the surgeon does not make a diagnosis of diverticulitis until after opening the abdomen, an error which frequently warrants criticism.

Read before the Columbus Academy of Medicine, December 4, 1933.

CLASSIFICATION

Intestinal diverticula are classified according to the time of their appearance, location, structure and position. The early writers utilized the terms "true" and "false" in their descriptions. It was intended to imply that the term "true" referred to the congenital type. The differentiation of the "true" from the "false" depends on the coverings of the sacculation. The "true" were supposed to contain all the coats of the normal bowel. In the "false", the muscular coat is missing, only the mucosa, submucosa, and serosa being present. More recently, writers have adopted the terms "congenital" and "acquired" and "complete" and "incomplete" which are more explanatory. It is not to be overlooked that undoubtedly all diverticula begin as "complete" and with increase in size, the muscular coat thins out and retracts losing its identity in the sacculation.

ETIOLOGY

The cause for the existence of diverticula along the course of the intestines may be said to be as yet not definitely established. That anatomical

defects in certain cases, of which the Meckel's type is an example, are established in embryonic life, is not to be denied. It has not with certainty been proved but what all diverticula in their beginning are of the congenital, complete type. Later, after they advance in development their muscular coat is lost, placing them in the incomplete or acquired type. There is room for more study and investigation from this standpoint. In 1878 Zenker[2] advanced the theory of pulsation and traction in the production of sacculations in the pharynx and esophagus, a factor which must be considered in development of diverticula in any portion of the alimentary canal. Contrary to experimental investigation, it is believed diverticula select an area of least resistance along the course of the bowel for presentment, usually that region where blood vessels enter and depart. Again, they often select an area where there is a lessened muscular supply; especially is this true in the sigmoid where as a rule they adjoin the appendices epiploica. Diverticula are never found to involve the rectum owing to the fact that the muscular bands fan out so to speak, completely enveloping this organ. In diverticula of the duodenum, embryonic pancreatic tissue rests have been demonstrated and offered as a primary etiological factor. Like aneurisms, with increased pressure (pulsion) or pull (traction) due to adhesions, increase in the size of the sacculation is naturally to be expected. It is well to postulate that a congenital hysto-anatomical predisposition accounts for the initiation of diverticula, and added secondary factors favor their further development.

FREQUENCY

Although the following figures to be quoted may appear rather high, they were obtained by referring to a number of the leading authorities and hospitals in the United States and Europe. Improved radiography and easier access to postmortem has shown diverticula of the intestines to exist much more frequently than was formerly thought. Boyd[3] has stated that *X*-ray studies have revealed the presence of duodenal diverticula in 1 or 2 per cent of all cases examined. It is known that Meckel's diverticula cause approximately 10 per cent of occlusions about the cecum (5 to 7 per cent).[4] Five to 17 per cent of all people past forty years of age have diverticula of the colon, 70 to 80 per cent of which involve the sigmoid. William Mayo to whom considerable credit is due for the development of our knowledge of diverticula, especially insight into their complications, estimates that 12 per cent of all cases of diverticula of the sigmoid result in a process of acute or chronic inflammation. It has been the writer's experience to encounter diverticulitis of the sigmoid in three cases out of 900 consecutive laparotomies.

Diverticula may be located on any portion of the alimentary canal from the mouth to the rectum. The most common location is the sigmoid as has been shown in the relative percentage of occurrences. Involving this portion of the bowel they are practically always of the acquired, incomplete type and frequently develop into clinical importance especially in people past forty years of age. It is at this period of life that the individual assumes more sedentary habits which encourage additional deposits of adipose tissue throughout the body and retardation of bowel elimination with its distention by feces and gas; this in turn naturally favors the development of diverticulosis. The position of the sigmoid, its mobility and inherent, reservoir function naturally favors it as that portion of the alimentary canal to develop the acquired type of diverticula.

Diverticula of the small bowel usually present themselves at the mesenteric attachment. The sacculations appear where the blood vessels enter the bowel, the so-called "weakened area of the gut", contrary to experimental findings which have demonstrated that a bowel having been removed from the body and placed under distention as well as a distended bowel occupying its normal position in an animal usually ruptures distal to its mesenteric attachment. The exception to the rule is the Meckel's type of diverticulum which in practically all cases surmount the convexed portion of the bowel distal to its mesenteric attachment. What has been said of the position occupied in the small bowel is not true in the case of the diverticula involving the colon. Here the sacculation adjoins the appendices epiploica, and are often buried in fat and obscured from vision.

In size diverticula vary from microscopic to that of a golf ball but usually are the size of a pea; especially is this true of the acquired type. It is likely that all diverticula are infinitesimal in the beginning gradually enlarging to proportions. They may be sessile, funnell, or pedunculated in shape.

PATHOLOGY

The pathology assumes the characteristics of a chronic irritation associated with an inflammatory process. Early in the body of the sacculation there occurs irritation, necrosis, and ulceration, with a thinning of the sac wall. Nature in its endeavor to avoid perforation throws out a mass formation of granulation tissue into which are implanted connective tissue cells and an abundance of fibrous tissue. Giant cells are frequently present and might lead to a mistaken diagnosis of tuberculous involvement. Stenosis is not uncommon although rarely complete. This condition is due more particularly to extrinsic bowel conditions resulting from peridiverticulitis.

Three cases are here reported in abstract which

briefly illustrate some of the typical symptoms encountered in diverticulitis of the colon.

REPORT OF CASES

Case No. 1. Z. D., age 51, female, admitted to hospital December 14, 1931, complaining of pain in lower abdomen referred to the back. She has borne two children by normal labors, menopause evident for two or three years, however, she had menstruated four weeks previous. The appetite until present illness was most excellent with an accompanying gain of weight and gradual assumption of sedentary habits. During the past two years, increasing constipation had developed until it had progressed to a marked degree. During the last few months an occasional show of blood in the stool was noticed and thought to be due to hemorrhoids. This was accompanied by flatulence and ribbon-like stools; she also reported suffering nocturia and frequency for the past three years.

P. I. December 4, 1931, the patient suffered an attack of cramp-like abdominal pain accompanied by several liquid stools, nausea, vomiting, and increasing abdominal distention. Feeling this was due to a dietary indiscretion she deferred calling her physician until December 7th at which time she began to suffer with chills and fever. Physical examination December 14th disclosed blood pressure 175/62, temperature 102:4, pulse 104, respiration 24. Tongue was coated, skin warm and moist with a slight yellowish tinge. General examination including pelvic and rectal was essentially negative except as has been mentioned and the presence of a tender mass high in the lower left quadrant obscured by marked intestinal distention. Extensive laboratory investigation shed no light in establishing a diagnosis aside from a process of elimination. *X*-ray examination revealed the presence of diverticula of the descending colon and of the sigmoid complicated by partial obstruction of the colon.

Laparotomy December 22, 1931, disclosed a large inflammatory mass involving the lower left colon and sigmoid inclosing an abscess and complicating diffuse peritonitis. The abscess was drained. The patient died December 23, 1931, as the result of the constitutional effects of a bacteremia, confirmed by the post-mortem findings of "suppurative diverticulitis of the sigmoid, suppurative phlebitis of the veins in the meso-sigmoid and also those of the rectum". Microscopic diagnosis, "purulent thrombosis of the inferior mesenteric veins".

Case No. 2. J. B. a hearty, robust, male weighing about 220 pounds, age 49, admitted to the hospital June 25, 1931. Gave a history of having been a hearty drinker, but never ill or attended by a doctor except for a genito-urinary infection complicated by urethral stricture. For past few years had occupied a position as elevator inspector for the State which placed him under sedentary habits inviting increase in weight and stasis of the bowels.

P. I. Forty-eight hours previous, the patient had stepped into an elevator that had been stopped about one foot below the floor level causing him to trip and fall. At the time, he felt immediate distress in the lower abdomen, and believing he needed a cathartic, he took Pluto water. In the course of a few hours, he had four evacuations of the bowels each with increasing pain. The following morning he called his attending physician. Temperature was 103:5, pulse 106; he was complaining of soreness throughout the lower abdomen, was nauseated and vomiting. He was given a dose of castor oil and later enemata, and pain controlled by morphine. The following morning he developed obstipation, pain continued and distention became marked.

General examination made at the hospital upon admission June 25, 1931, was essentially negative. It was made hurriedly due to the urgent condition of the patient who seemed in extreme pain, flouncing from side to side and calling for water. Respirations were embarrassed, breath foetid, tongue coated. The abdomen was distended and tympanitic, accompanied by marked rigidity especially in the lower quadrants. Generalized tenderness was present, however, it was impossible to outline any definite area of intensity. Rectal examination disclosed the presence of a hard, tender mass occupying the pelvis, impinging on the bladder and extending essentially to the left. A No. 12 catheter was introduced into the bladder with considerable difficulty owing to the structure of the urethra and about 200 c.c. of urine withdrawn.

Operation disclosed a diverticulitis of the sigmoid complicated by peridiverticulitis, perforation and peritonitis. Gross pathology, "Masses of mesenteric fat and cystic masses apparently inflamed. Fibrous appendix." Microscopical, "Areas of infection about the epithelial line cyst (diverticula), chronic obliterative appendicitis". Diagnosis, "Diverticulitis imposed upon diverticulosis". Patient died June 25, 1931.

Case No. 3. M. K., female, age 44, weight 214 pounds, height 5 feet 5 inches tall, admitted to hospital May 28, 1929, complaining of pelvic pain, backache and a show of blood from either vagina or rectum at time of urination and defacation. Cholecystectomy and appendectomy had been performed two years previous. For the past three weeks aside from the above mentioned bleeding she suffered a feeling of pressure in the pelvis upon assuming the sitting posture. Bowels had been regular until the past three days. Since then they had been confined and it was necessary to relieve the pain with morphine.

Examination disclosed a large, irregular, tender mass occupying a fixed position in the pelvis, the presence of which was confirmed both by pelvic and rectal examination. General examination was negative, the tongue was coated, temperature 99:8, pulse 90, intermittent. Blood showed a leucocyte count of 15,800 with 84 polys; urinalysis was negative.

Laparotomy May 29, 1929, revealed a large mass involving the sigmoid, left tube and ovary. It was extirpated including in mass the tube and ovary and submitted for pathological examination which was reported as follows:

Gross: A mass of tissue generally tubular in its contour measuring 8x4 cms. Upon section gives the porky appearance of newly formed connective tissue.

Microscopical: The tubular appearance is confirmed. Bands of muscle tissue remain arranged in a circular manner but for the most part sections consist of young connective tissue cells and cellular infiltration. The landmarks are destroyed.

Diagnosis: A subacute inflammatory process that has been in existence some weeks resulting in the formation of new connective tissue.

The pelvis was drained through a posterior vaginal celiotomy. Recovery was uneventful, the

patient leaving the hospital on the 13th day following operation.

SYMPTOMATOLOGY

The mere presence of diverticula is not productive of symptoms. It is when the sacculations become filled with scybalous fecal matter that symptoms become manifest. Seldom is diverticulosis of the small intestines of consequence unless the sacculations be of considerable size. Irritation with resulting inflammation is less apt to occur in this portion of the bowel due to the liquid nature of the fecal content. In the sigmoid, "the hot-bed of diverticulitis", this condition pertains. The fecal content of diverticula in this region becomes scybalous, the concretions in turn produce necrosis or a stercoral ulcer, and as the diverticulitis advances, perforation with resulting local peritonitis occurs. Then again bacteria or their toxins penetrate through the thin walled sacculations with resulting peridiverticulitis. Pain may be considered as the outstanding symptom. It is naturally dependent for its location on the position of the bowel involved. In diverticulitis of the sigmoid, lower right quadrant pain is in evidence. Pain in this region accompanied by gaseous distention, constipation, or constipation alternating with diarrhea in patients past middle life should arouse a strong suspicion of diverticulitis of the sigmoid especially if accompanied by a palpable mass in the lower right quadrant. In general the symptomatology so strongly resembles that of appendicitis that the European doctor has designated it as "left-sided appendicitis". There is often blood in the stool which is likely to cause the condition to be confused with carcinoma. Diarrhea is said to be present in about 11 per cent of cases. Rectal tenesmus with the passage of a small amount of fecal material, mucus, gas, and occasionally pus are symptoms frequently in evidence. Seldom if ever is the bowel completely obstructed. Laboratory findings are of little value in establishing a diagnosis aside from eliminating other conditions.

DIAGNOSIS

A corpulent constipated sedentary person forty years or more of age developing the above mentioned symptoms should be thoroughly examined by *X*-ray wherein lies the chief anchor to a diagnosis. A barium enema followed by immediate twelve hour, twenty-four hour, sixty-four hour, and occasionally seventy-two hour fluoroscopic and flat *X*-ray plate findings confirms the diagnosis. The diverticula will be found to remain filled following the elimination of the bulk of barium from the colon. The proctoscope may be used but is as a rule of little value.

DIFFERENTIAL DIAGNOSIS

There are several conditions such as left-sided appendicitis, volvulus of the colon, the inflammatory conditions under which must be included both the ulcerative and hypertrophic types of tuberculosis, beginning typhoid fever, and the condition known as fibromatosis of the colon. It is also necessary to consider the secondary inflammatory conditions such as stercoral ulcers resulting from the accumulations of fecal masses as well as carcinoma, especially the cauliflower type. The confusion that may arise in the consideration of the above mentioned conditions depends largely on the acuteness or cronicity of the diverticulitis.

A complete differentiation of this condition is too lengthy to be embodied in this article. A thorough knowledge of conditions to be differentiated will enable one to arrive at a diagnosis by a process of elimination. The most common complication is local peritonitis—general peritonitis seldom occurs. The local peritonitis results from perforation which as a rule is followed by peridiverticulitis with abscess formation. The abscess is usually well walled off and more or less chronic in its manifestation. With advancement of the inflammatory process, fistula formation becomes manifest. These fistulas may establish communication between the bowel and bladder (vesicocolic), between the small bowel and colon (entercocolic), or between the bowel and skin surface (external fistulas). In one of my personal cases of suppurative diverticulitis of the sigmoid, postmortem findings revealed a complication of suppurative phlebitis of the veins in the meso-sigmoid, also of the veins of the rectum. Absorption of bacteria and their toxins from pus pockets in the recesses posterior to the sigmoid and between the layers of the meso-sigmoid frequently leads to septicemia with a fatal termination.

TREATMENT

Prophylactic treatment is important. People should be forewarned against sedentary habits with the approach of middle life. Indulgence in starches and carbohydrates especially if there is the tendency to gain weight should be curtailed to a minimum. Constipation must be corrected, if present, by the use of mineral oil and enemas. All that may be said relative to prophylaxis pertains to the medical treatment of diverticulitis when in evidence. Quoting from Lynch,[5] "There is no medical treatment for diverticulosis any more than there is medical treatment that will abort appendicitis". He further states, "In my opinion, all people with diverticulosis will be better off with appendectomy; diverticulitis will be less likely to develop."

With the advent of diverticulitis and its complications which have been enumerated, a surgical emergency naturally presents itself and must be met according to the several necessities for the relief of the complications present. The fact that the surgeon is dealing with a fat, frequently debilitated individual in a period of life

when any surgical procedure carries with it a decided element of risk, should not be lost sight of. The preparation for operation should be thorough, the anesthetic selected, and the approach to the seat of trouble careful and cautious. Abscesses should be opened and drained. If the pathological involvement is extensive it is better to establish drainage of the bowel by colostomy, the stoma being placed at sufficient distance from the seat of trouble to insure ample territory for subsequent operations. The elimination of fistulous tracts is fraught with no little shock to the patient and difficulty to the surgeon. They frequently require, if a cure is to be had, a resection of that portion of the bowel from which the fistula arises.

327 E. STATE STREET.

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DISCUSSION

ROSWELL S. FIDLER, M.D., Columbus: The anatomical basis of diverticulosis consists of an outpouching or outpocketing along the lumen of the bowel. These pockets usually form into the peritoneal covered and fat containing appendices epiploicae from which the diverticulum derives its serosal layers. The mucosal and submucosal layers of the bowel herniate into these pouches and at times carry with them the muscular layer. Subsequent pathological changes must therefore involve these various layers and it is to be expected that any inflammatory reaction in such diverticulae will behave in much the same manner as would inflammation of that other well known vertigial pouch, the vermiform appendix.

All diverticula possess a narrow orifice opening into the lumen of the bowel together with a weak or entirely absent muscular layer. The pouch soon becomes impacted with fecal material in much the same manner as a chronic fibrotic vermiform appendix which cannot empty itself because of its weakened musculature. This fecal impaction and obstruction at the neck of the pouch may initiate an acute inflammatory reaction.

ACUTE DIVERTICULITIS

Acute diverticulitis can best be compared to an acute catarrhal appendicitis, i.e., the inflammation begins in the mucosa itself. The fecal impaction produces an atrophy and erosion of the mucosa followed by an active ulceration. From this ulceration the inflammation spreads to involve all the layers of the diverticulum and in a large percentage of cases the serosal layer is perforated. With perforation through the peritoneum a localized abscess forms about the intestine and the transition into a localized or generalized peritonitis is soon accomplished. The abscess, if not drained surgically, frequently results in the formation of fistulous tracts, either external or internal. Purulent thrombosis of the mesenteric vein is frequent where abscess formation has occurred.

CHRONIC DIVERTICULITIS

Chronic diverticulitis does not usually develop on the basis of an old diverticulosis but when it does it is more likely to run a chronic and uncomplicated course. True chronic inflammation in a diverticulum begins as a submucosal process with the passing of bacteria or their toxins through the intact mucosa. Round cell infiltration of the submucosa represents the immediate response but the reaction soon becomes one of productivity with the active proliferation of fixed tissue cells, granulation tissue and, in some cases, of giant cells. The process may extend into the mesentery where the proliferative reaction produces marked tumefaction. It is these cases, which Wilson calls peridiverticulitis, that may mislead the clinician into a diagnosis of malignancy because of the extensive and fixed masses of tumefaction. Perforation of the mesentery may occur with concomitant localized abscess formation.

DIVERTICULITIS AND CARCINOMA

Carcinoma can, and does, develop an intestinal mucosa; the diverticula being lined with mucosa, carcinoma can, and sometimes does, develop in a diverticulum, but there is little evidence that carcinoma is the result of diverticulitis. The association is so uncommon as to be questioned. Rankin and Brown assert that "the mimicry of carcinoma is more theoretic than real" and report 227 cases of diverticulitis in which carcinoma was found in only four cases. They further report 679 cases of carcinoma of the sigmoid in which diverticulitis was found in only four cases.

Diverticulitis results in an extrinsic inflammatory reaction with a constriction of the extrinsic coats of the bowel in contradistinction to carcinoma which usually begins within and progresses outward.

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HERBERT V. WEIRAUK, M.D., Columbus: It is a matter of more than passing interest that LeWald is credited with making the first *X*-ray diagnosis of diverticula of the colon as recently as 1914. The condition had, of course, been described many years before the first *X*-ray diagnosis was made, and cases had been reported by Mayo, Giffin, Wilson and others.

Dr. Chapin, in his paper, has described diverticula occurring in connection with all portions of the intestinal tract, but I shall confine my remarks to diverticula of the colon.

The clinical potentialities of colonic diverticula are less appreciated, I believe, than those in connection with any other portion of the intestinal tract. The final diagnosis in cases of colonic diverticula is made by means of the *X*-ray examination. Either the barium meal or the barium enema may be used in the demonstration of colonic diverticula. Some authors believe that the use of the barium enema is contra-indicated due to the possibility that the increased pressure in an involved segment may cause rupture in one or more of the diverticula. I believe, however, if the barium enema is given without too much pressure that there is very little danger associated with its use.

If we administer a barium enema, allow the patient to expell same, and then introduce air into the colon, the *X*-ray film will show the diverticula particularly well. This is the so-called double contrast enema.

Mackey of Milwaukee reported before the Radiological Society of North America, a most interesting series of cases occurring in the same family which suggests the possibility of a hereditary tendency toward the development of diverticula of the colon. This is the only report of its kind so far as I have been able to find in the English literature. The series, in brief, consisted of a maternal grandmother, mother, two maternal aunts, one cousin, a niece, and three sisters. All but one of these individuals had complained for years of abdominal discomfort, distention, constipation alternating with diarrhea, and toxemia. The chronic course of the disease was interrupted occasionally by severe cramping pains in the lower abdomen, fever, vomiting, and obstruction of the bowels. The acute attack very frequently terminated with sharp knife-like pains followed by a stool containing blood and pus. As Mackey states in his report, the similarity of the symptoms presented by the members of this family were so apparent that it became a family tradition that all of the members of the family were subject to intestinal trouble. The older members of the family died without definite diagnosis being made, but in the case of the three sisters in the third generation, two of whom had marked intestinal symptoms, and one of whom was in good health, Mackey was able to demonstrate by the barium enema, the presence of multiple diverticula of the colon in each patient.

Diverticula of the colon are of slow development and we recognize in the *X*-ray findings a pre-diverticular condition. When we find an individual suffering from constipation with some abdominal discomfort, and find certain segments of the colon contracted, and with the colon walls presenting a saw-toothed appearance instead of the normal haustra, we have definite evidence of a pre-diverticular state. The segments of the colon proximal to the involved segment are usually dilated. When diverticula have definitely developed we find definite sacculations in connection with the involved segment of the colon. As the sacculation increases in size, the infundibulum connecting it with the lumen of the colon becomes elongated and narrowed and in the final stage the sacculation may become entirely dissociated from the segment of the colon from which it arises. The affected portion of the colon becomes much thickened in the later stages.

A number of cases have been reported of rupture of a diverticulum of the colon with formation of a circumscribed abscess. Such an abscess may, of course, occur in connection with any portion of the colon. It should be stated, however, that the distal half of the colon is much more prone to development of diverticula than is the proximal portion. A number of cases of walled-off abscess following rupture of a diverticulum of the colon have been diagnosed by the *X*-ray examination. If we have suspected a case and the patient is given a barium enema or barium meal, and if we find an extra colonic collection of gas with some diverticula in the vicinity, the evidence is strongly to the effect that the localized collection of gas lies in an abscess cavity which has its course in a ruptured diverticulum. In some cases the barium passes into the abscess cavity and if a picture is taken with the patient in the upright position, we are able to demonstrate a definite fluid level with traces of barium in the fluid.

THE ELECTROCARDIOGRAM AS AN AID TO THE SURGEON IN WOUNDS OF THE HEART

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IN a case of penetrating thoracic wounds over the precordium where the patient is brought in with the classical symptoms of shock, namely, anxious expression with restlessness; possibly unconscious; pallor and cyanosis; skin covered with a cold sweat; usually dyspnoeic; and the pulse feeble and fast, the surgeon is called upon to decide whether to open the thorax immediately or let well enough alone. Delay may be costly, but unnecessary interference may be likewise so when dealing with a patient of this kind. Beekman,[1] who a few months ago reported two very interesting cases of cardiac wounds, is of the opinion that every person with a wound of the heart should be operated upon, especially if the patient shows any signs of cardiac tamponade —acute compression of the heart due to collection of blood in the pericardium—which is really responsible for the death in these cases, and not so much to the loss of blood. Although the bleeding may be slow, the pressure developing as a result of the tamponade may kill in a short time, since the pericardial sac is rather small and the pericardium is non-yielding.

The roentgenologist who, according to White[2] is the first one to be able to diagnose this condition, is rather helpless in these cases since he is obliged to deal with a patient that is not amenable to manipulation. Besides, according to Holmes and Ruggles[3], less than 200 cc. of fluid in the pericardium cannot be demonstrated by the *X*-ray.

Of course, skillful use of the aspirating needle is of value in determining the presence or absence of blood in the pericardial sac. However, there is now a much safer and simpler procedure—the electrocardiogram. For Scott, Feil, and Katz[4] and Katz, Feil and Scott[5] in two articles in the *American Heart Journal*, the first dealing with clinical, and the second with experimental evidence, have shown that cardiac tamponade as a result of

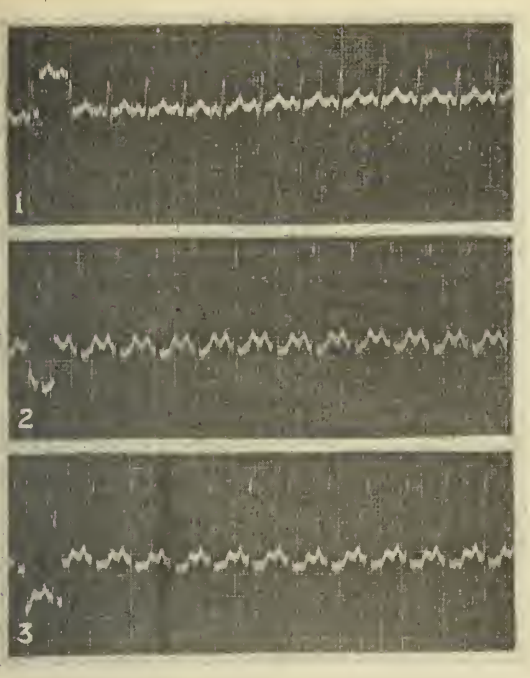


Fig. 1—Six hours after accident. Rate—170 per minute. S-T deviation in Leads II and III is probably due to the rapid heart rate. No evidence of tamponade. (1 cm.=1 millivolt).

pericardial effusion or hemopericardium causes pressure upon the coronary arteries resulting in an anoxemia of the myocardium thereby giving a typical "coronary 'T' wave"[6] in the electrocardiogram.

Their first case under discussion presented typical signs of acute pericardial effusion, but whose electrocardiogram was so typical of recent myocardial infarction that the clinical diagnosis of coronary thrombosis was substituted. Much to their surprise the post-mortem examination revealed no significant changes either in the myocardium or in the coronary arteries, but a rather slight hemorrhagic effusion into the pericardial sac from a ruptured aneurysm of the ascending aorta. Two more cases of similar nature are discussed in the same article.

REPORT OF CASE

J. J., male, negro, age 15, was brought to the St. Elizabeth's Hospital of Youngstown, Ohio, on the service of Dr. C. D. Hauser, in extreme shock, having been stabbed in the precordial region with a penknife.

Family History—Mother, father, one brother and one sister living and well.

Personal History—Essentially negative.

History of Present Illness—Patient was stabbed in the precordial area during a quarrel. Wound is in the third interspace to the right of the sternum.

Physical Examination—Patient is thirsty. Feels weak and "light-headed". Slightly dyspnoeic. Temperature 96. Pulse 142 per minute. Respiration 32 per minute. Blood pressure 85 systolic, diastolic not obtainable. Head and neck negative except for anemia of mucous membranes. Lungs—voice and breath sounds slightly diminished in left chest at region of apex. No rales. Heart sounds diminished. Apex in fourth interspace just inside mid-clavicular line. Abdomen, normal.

X-ray Report—Rather doubtful as to the evidence of fluid in the pleura or pericardium. The heart beat is so small in volume that it cannot be discerned under the fluoroscope.

(At a cardiac clinic held by the author some time previously the subject of electrocardiography in relation to pericardial effusion was discussed. As a result the surgeon requested an electrocardiogram.)

Electrocardiographic Findings—Six hours after the accident the electrocardiogram (Fig. 1) reveals a tachycardia of 170 per minute. No evidence of tamponade. The following morning, fifteen hours after the accident, another electrocardiogram was taken (Fig. 2). The rate had slowed to 130 per minute. Still no evidence of cardiac tamponade. The clinical notes at this time are as follows: Patient much better. Pulse rapid and regular, not very strong. Heart sounds normal. Temperature 100.

From this time on the patient's condition was one of continued improvement. Ten days after the accident the third electrocardiogram (Fig. 3) shows a rate of 60 per minute. Normal in all respects. Fifteen days after admission the patient was discharged as recovered. There was no surgical interference, which decision was based on the early electrocardiographic findings.

COMMENT

The concensus among clinical and laboratory investigators seems to be that the peculiar configuration of the "T" wave in coronary occlusion is due to myocardial anoxemia. To quote Kountz

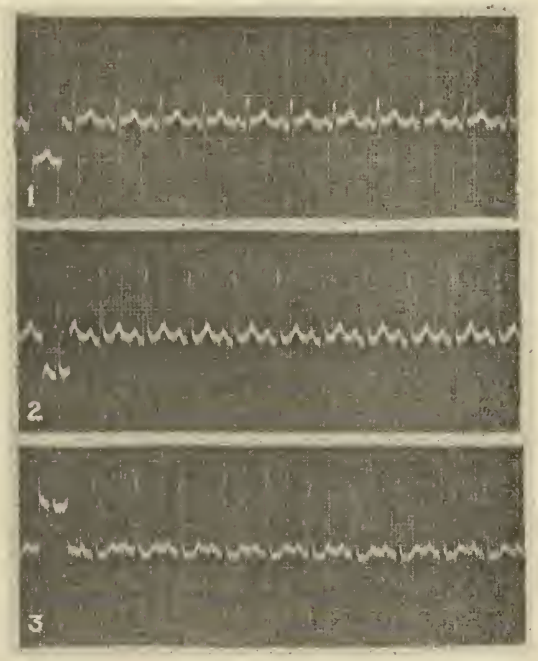


Fig. 2—Fifteen hours after accident. Rate—130 per minute. S-T deviation less marked than in Fig. 1. No evidence of tamponade. (1 cm.=1 millivolt).

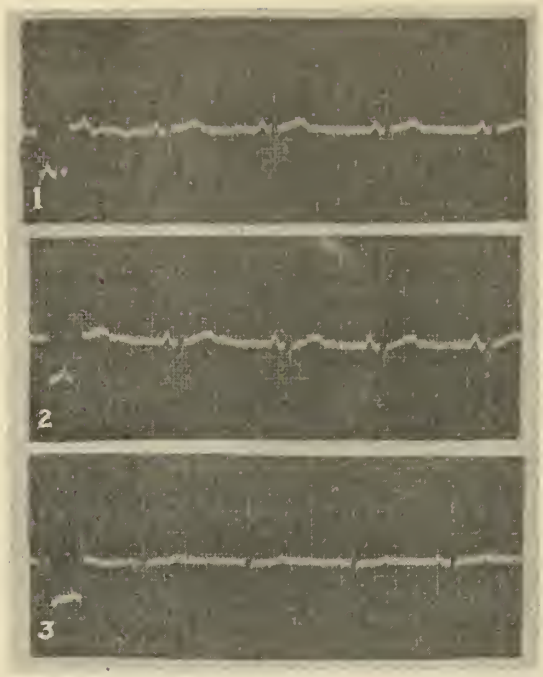


Fig. 3—Ten days after accident. Rate—60 per minute. Otherwise negative. (1 cm.=1 millivolt).

and Gruber[7], "In the study of the electrocardiogram of a dog in a state of general anoxemia it was found that the complexes resembled those described in coronary occlusion. Vasoconstrictor substances by coronary constriction accentuated the picture to a most extreme degree."

Scott[4] and his co-workers from clinical observation state that tamponade of the heart results in anoxemia of the heart muscle. Katz[5] and his associates have shown experimentally in dogs by increasing intra-pericardial pressure by injections of oil into the sac that these experimental electrocardiographic changes which resemble the clinical curves seen in recent occlusion of the left coronary artery can be explained on the basis of severe anoxemia of the heart. In a later article, Feil, Katz, Moore, and Scott[8] reiterate that these peculiar changes observed in the electrocardogram in pericardial effusion are due to "Myocardial ischemia resulting from increased hydrostatic pressure in the pericardial sac." Other observers[9, 10, 11, 12] report similar findings.

In view of the aforesaid, one is justified in expecting in a case of a stab wound of the heart, where a hemopericardium is suspected, a definite change in the electrocardiogram such as is found in recent coronary occlusion, particularly when the pulse is as rapid as it was in the case described above, for as Feil and associates[8] have found, tachycardia superimposed upon an already impaired coronary circulation will further accentuate the electrocardiographic picture of recent coronary occlusion.

SUMMARY

1. Report of a case of stab wound in the heart region.

2. The value of the electrocardiogram in excluding hemopericardium is discussed.

604-5 CENTRAL TOWER.

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— OSMJ —

New American Medical Directory Full Of Valuable Information

The names of 8,769 Ohio physicians appear in the 13th (1934) edition of the American Medical Directory, compiled and published by the American Medical Association, recently off the press and being distributed to subscribers.

The new edition of the directory which sells for $15.00, is the first issued since 1931. It contains the names of 116 more Ohio physicians than the 1931 edition. The physicians listed in the directory total 178,516, an increase of 6,167 over the total names contained in the 12th edition.

As a source of valuable information on physicians, medical schools, hospitals, medical examining boards, special medical societies, etc., the American Medical Directory is without an equal.

The 13th edition contains the names of American physicians located in foreign countries; information relative to the various state examining boards, state medical laws, state licensing fees, etc.; data regarding 458 medical schools and 677 hospitals approved by the Council on Medical Education and Hospitals and those approved for residencies in specialties, and pertinent information regarding special medical societies, government services, public health departments, officers of state and county medical societies, etc.

THE SIGNIFICANCE OF BLOOD IN THE CEREBROSPINAL FLUID

By SIDNEY W. GROSS, M.D.,
CLEVELAND, OHIO

IN the routine examination of the cerebrospinal fluid, blood, either macroscopic or microscopic, is occasionally found. The interpretation of this finding is often difficult, and its true importance is frequently disregarded, being attributed to the trauma incident to the spinal or cisternal puncture. However, whenever blood is found in the cerebrospinal fluid, its presence should excite a rigid investigation to determine if possible its exact source. In the literature one finds recorded many conditions in which blood may be found in the cerebrospinal fluid, but a systematic discussion of this sign has not come to my attention. Text books of neurology and treatises on the cerebrospinal fluid are significantly silent in this regard. Since the introduction of spinal puncture by Quinke in 1891, the cerebrospinal fluid has been studied from many angles. Its physical properties, chemical composition, cytology, and bacteriology have become well known, and aberrations from the normal are easily recognized, and are of extreme diagnostic importance.

The recognition of blood in the cerebrospinal fluid is very simple. Macroscopic blood is obvious. Blood incident to the trauma of the puncture can usually be easily recognized. The first specimen is the most deeply colored, clots on standing, and as subsequent specimens are removed they tend to become clear. The supernatant fluid of a centrifuged specimen of cerebrospinal fluid which contains blood due to the puncture is clear, whereas spinal fluid containing blood from other sources is most often discolored by pigments resulting from the disintegration of the red cells, and the supernatant fluid of a centrifuged specimen is xanthochromic. Microscopic blood can be easily recognized. Specimens of cerebrospinal fluid should be examined as soon as obtained. Red cells can be seen in the unstained specimen with the high power lens. To determine their number, a count should be made without, and with the addition of glacial acetic acid according to the accepted methods. Red blood cells in the cerebrospinal fluid which are the result of the trauma of the puncture, when examined freshly, have a smooth, circular outline. Old blood cells, from sources other than the trauma incident to the puncture, are for the most part crenated. The tendency to regard blood in the cerebrospinal fluid as due to a faulty puncture without carrying out the simple tests outlined above can not be too severely condemned. After one has mastered the technic of spinal puncture the number of so-called "bloody taps" becomes reduced to a minimum, and the presence of blood should always warrant a careful search for its source.

The conditions in which blood may be found in the cerebrospinal fluid may be classified as follows:

I. Trauma
II. Infection
III. Toxic
IV. Vascular disease
V. Neoplastic disease
VI. Systemic and metabolic disorders.

I. TRAUMA

Birth Injuries. Glaser[1] and others have found blood in the cerebrospinal fluid of an appreciable number of premature new-borns. In many there are no symptoms, or only slight evidence of central nervous system involvement. In more severe birth injuries the symptoms are usually alarming, and a very large percentage of babies dying at birth or within the first two weeks of life show intracranial hemorrhage at autopsy[2]. The source of blood in the cerebrospinal fluid of new-borns was analyzed in post-mortem material by Capon[3] in 80 cases. He found:

1). Small tentorial tears; 2). Rupture of the great vein of Galen; 3). Tears in the veins entering the superior longitudinal sinus; 4). Tears in the longitudinal, transverse, or straight sinuses; 5). Injury of the choroidal veins.

Cranio-cerebral injuries. Following head injuries blood is often found in the spinal fluid, and is not infrequently the cause of many of the alarming symptoms. The place of lumbar puncture in the treatment of head injuries is still the subject of much controversy. However, punctures carefully done, with the use of a needle of small caliber, and the slow withdrawal of fluid governed by pressure readings, are safe, and the removal of the bloody fluid is often followed by immediate benefit to the patient. The studies of Bagley[4] in dogs have shown that blood per se is an irritant when introduced into the subarachnoid spaces, and if allowed to remain produces a marked reaction of the meninges.

Spinal Injuries. Severe injuries to the vertebral column are often accompanied by laceration of the spinal cord with the tearing of blood ves-

sels. On lumbar puncture the fluid is often found to contain blood.

Cranial Operations. Blood is present in the cerebrospinal fluid to a greater or lesser degree after nearly all cranial operations. Often it is the cause of the high temperature and drowsiness during the early post-operative period. Its removal, either by spinal or ventricular punctures, is not infrequently followed by marked benefit to the patient.

II. INFECTION

Meningeal irritation may occur in the course of any infectious disease. This may be due to actual invasion of the subarachnoid spaces by pathogenic organisms with a resultant purulent meningitis. However, occasionally the symptoms are the result of bleeding into the subarachnoid spaces due to rupture of diseased pial vessels. The spinal fluid in these cases shows an abundance of red blood cells in various stages of disintegration. The fluid is most often tinged canary yellow by altered blood pigments, and the protein content is greatly increased. Neal, in a paper on "Spontaneous Meningeal Hemorrhage",[5] reported 35 cases in which blood was found in the spinal fluid in patients having signs and symptoms of meningeal irritation. The possible causes were:

Epidemic meningitis, 4 cases; septicemia, 1 case; endocarditis, 1 case; pneumonia, 1 case; syphilis, 1 case; mitral lesion, 3 cases; hypertension, 1 case; undetermined, 24 cases.

Thus, of twelve cases in which there was an apparent cause, eight were associated with an infectious disease. Syphilis as a cause of subarachnoid hemorrhage was the basis of Sands' paper[9] in which two cases of neurosyphilis complicated by meningeal bleeding were reported. Symonds[7] analyzed 127 cases of subarachnoid hemorrhage and found syphilis to be the primary cause in ten. Subarachnoid hemorrhage has been observed in the course of whooping cough, measles, malaria, tuberculous meningitis[3], streptococcic meningitis, anthrax meningitis, in the course of rheumatic fever[9], and in many other infectious diseases.

III. TOXIC

Many cases of "hemorrhagic encephalitis" in infants have been reported following the intramuscular injection of sulpharsphenamine in the treatment on congenital syphilis, and meningeal bleeding has been observed following the administration of arsphenamine in adults[10], and after the use of other heavy metals. Meningeal hemorrhage has occurred following antityphoid vaccination[11], and following the administration of other vaccines and sera.

IV. VASCULAR DISEASE

The recent interest in "spontaneous subarachnoid hemorrhage" has led to the frequent recognition of this striking clinical entity in neurological and medical clinics. A typical case was observed by the author in 1929.

The patient was a white female of 50 who had had a moderate hypertension of about ten years duration. Except for periodic severe headaches, and attacks of lumbo-sacral pain she thought herself to be in good health, and was gainfully employed as a secretary. One day, while in apparent good health, she suddenly complained of severe pain at the top of her head which lasted for several minutes. Her speech became thick, and she was said to have "fainted". She was seen about fifteen minutes after the onset of the attack. At this time she was unconscious, her pupils were equal and reacted to light sluggishly. There was a right facial weakness, and a markedly positive Babinski on the right, with increased tendon reflexes in the right lower extremity. Later that afternoon, cervical rigidity, and a bilateral Kernig were observed. The temperature was 101°.

The next morning a spinal puncture yielded a uniformly bloody fluid. After centrifugation the supernatant fluid was tinged yellow. A diagnosis of subarachnoid hemorrhage was made. Following the spinal tap the patient became less comatose. The punctures were repeated daily. The fluid became less bloody, but remained xanthochromic for several days. Gradually the patient became more alert. She had a slight right hemiparesis, which had practically disappeared at the time of her discharge from the hospital several weeks later. About a year later, when the patient was seen, she was in fairly good health, though she still complained of occasional headaches.

The history of this patient was similar to those reported by McIver and Wilson [12], Strauss, Globus and Ginsberg[13], and Bagley[14]. In the cases which came to autopsy, rupture of a cerebral aneurysm, most often the result of arteriosclerotic changes in the vessel walls, was a frequent finding. However, syphilis, trauma, infected emboli, and congenital defects were also given as the causes of disease of the vessel wall which led to the formation of an aneurysm. Recently, especially since the work of Fearnsides[15], the rôle of congenital weakness of the vessel walls in the formation of intracranial aneurysms has received considerable attention, and is now believed to be an important factor in their causation, if not the most important factor. Fearnsides found 0.57 per cent of intracranial aneurysms without inflammatory changes in the vessel walls in a study of 5432 head post-mortems. Busse[16], in a review of 400 cases found congenital anomalies of the anterior communicating artery a frequent occurrence. In about 10 per cent of the cases aneurysms were present. Schmidt[17] believed that the great mapority of spontaneous subarachnoid hemorrhages were due to rupture of cerebral aneurysms, and that most cerebral aneurysms at some time in their history bleed into the subarachnoid space.

Blood may find its way into the cerebrospinal

fluid from intracerebral hemorrhages which rupture into the ventricle or subarachnoid space. These cases can usually be recognized by the presence of well marked focal signs, most often a severe hemiplegia which persists, and the failure of improvement following the removal of the bloody spinal fluid by lumbar puncture.

Bleeding into the subarachnoid space from vascular malformations has been reported on several occasions. Bagley[4] had two cases of meningeal bleeding in which venous malformations were found, and hemorrhages from cerebral arteriovenous aneurysms, many of which are developmental in origin, are not rare[18].

V. NEOPLASTIC DISEASE

The tendency for hemorrgages to occur in certain gliomas of the cerebral hemispheres is well known. In the glioblastomas (spongioblastoma multiforme of Globus and Straus) this tendency is especially marked. However, these tumors usually arise deep in the substance of the brain, so that when bleeding occurs in them it rarely reaches the cerebrospinal fluid spaces, though on rare occasions it may be so. Straus, Globus, and Ginsberg[13] report a case in which a tumor had broken through to the surface with resulting subarachnoid hemorrhage. Bleeding into the subarachnoid space or ventricles may occur occasionally in other neoplastic diseases of the brain. This has been observed in a tumor of the choroid plexus[4], and in various angiomatous intracranial neoplasms.

VI. SYSTEMIC AND METABOLIC DISTURBANCES

The occurrence of hemorrhages into the cerebrospinal fluid spaces in hemophilia and purpura has been long recognized[19]. The importance of determining the bleeding time and clotting time in cases of obscure subarachnoid hemorrhage, especially in young individuals, should be emphasized. Subarachnoid hemorrhage has been observed in scurvy, leukemia, severe anemias, diabetes, toxemias of pregnancy, during asthmatic attacks, and in other systemic disturbances.

SUMMARY

In this communication an attempt has been made in a general way to indicate the many conditions in which blood may be found in the cerebrospinal fluid. When blood is present in the subarachnoid space its judicious removal, using a lumbar puncture needle of small caliber, with manometric control to prevent a too rapid reduction of the cerebrospinal fluid pressure is a safe and beneficial procedure.

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— OSMJ —

New Books Received

The Laboratory Notebook Method In Teaching Physical Diagnosis and Clinical History Recording, by Logan Clendening, M.D., professor of clinical medicine, University of Kansas; The C. V. Mosby Company, 3523 Pine Boulevard, St. Louis, publishers; price, 50 cents.

The Spastic Child—A Record of Successfully Achieved Muscle Control in Little's Disease, by Marguerite K. Fischel, Florissant, Missouri; the story of a mother's experience with two children suffering with Little's disease and a description of the course of treatment she devised to combat this malady, written at the urgent request of physicians who had been called to treat the cases; The C. V. Mosby Company, 3523 Pine Boulevard, St. Louis, publisher; price, $1.50.

The Management of Fractures, Dislocations and Sprains, by John Albert Key, M.D., clinical professor of orthopedic surgery, Washington University, School of Medicine, and H. Earle Conwell, M.D., orthopedic surgeon, Tennessee Coal, Iron and Railroad Company, Birmingham, Ala.; a treatise for the student, the general practitioner and the surgeon, with special reference to injuries received in industry and compensable under workmen's compensation statutes. C. V. Mosby Company, 3523 Pine Boulevard, St. Louis, publishers; price, $15.00.

EIGHTY-EIGHTH ANNUAL MEETING

NEIL HOUSE, COLUMBUS, OHIO

Thursday, Friday and Saturday, October 4th, 5th and 6th, 1934

GENERAL SESSIONS

Opening Session

Thursday, October 4, 9:00 A. M.

Meeting Place—Junior Ball Room, northeast corner, Mezzanine Floor, Neil House.

This session is combined with the first session of the House of Delegates. See Page 581.

Second Session

Thursday, October 4, 11:00 A. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

DIABETES MELLITUS—by R. T. Woodyatt, Chicago, Illinois.

Discussion of emergencies occurring in the course of Diabetes.

Third Session

Thursday, October 4, 8:00 P. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

1. Annual address of the President-Elect John A. Caldwell, Cincinnati.
2. Annual address of the retiring President C. L. Cummer, Cleveland.
3. Presentation of Past President's gavel to retiring President—H. M. Platter to C. L. Cummer.
4. Address by Dr. Charles P. Emerson, Indiana University, on "Psychoneurotic Reactions".
5. Informal reception in honor of President and President-Elect. Music.

Fourth Session

Friday, October 5, 9:00 A. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

Paper No. 1—9:00 to 9:30

SOME RECENT ADVANCES IN THE TREATMENT OF PERIPHERAL VASCULAR DISEASES—by Mont R. Reid, Cincinnati.

During the past ten or fifteen years, there has been a very active interest in the diagnosis and treatment of peripheral vascular diseases.

An attempt will be made to give the classification of the peripheral vascular diseases and to evaluate the various methods of treatment which have been advocated. Special attention will be given to the use of negative pressure in the treatment of these conditions as well as short reference to some recent experimental work done in our laboratory. Lantern slides.

Paper No. 2—9:30 to 10:00

AMOEBIASIS—by Clayton C. Perry, Cleveland.

Too much emphasis cannot be placed on this disease, due to the marked spread of the infection in the past few years. There are two types of amoebiasis, the dysenteric, and the non-dysenteric. The period of incubation is from seventy to ninety days. The disease is spread by carriers and poor sanitation. The entamoeba and cysts are taken into the gastro-intestinal tract. The amoeba are killed by the hydrochloric acid and the cysts pass into the large intestine unharmed. The first site of colonization is in the cecum and the resultant pathology is usually limited to the large bowel. Diarrhoea, cramps, and loss of weight are the symptoms in the dysenteric type, whereas vague abdominal discomfort, fatigue represents the non-dysenteric type. The ulcers are pathognomonic and the treatment must be persistent and carried on over a long period of time. Lantern slides.

Fifth Session

Friday, October 5, 10:00 A. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

Program Presentation by Members of the Teaching Staff of Ohio State University, Columbus.

PROGRESS IN TUBERCULOSIS

Paper No. 1—10:00 to 10:40

BACTERIOLOGY, CHEMISTRY AND IMMUNOLOGY—by C. A. Doan.

The phenomenon of bacterial dissociation and its relationship to virulence, and to progressive or quiescent tuberculous lesions presents an entirely new point of approach to the problem of therapy. Specific immunologic reactions applicable to a study of the clinical disease have been based upon demonstrable antigenic variations in the tubercle bacilli. Chemical studies of acid fast organisms have produced fractions, which, when subjected to biological testing, have induced variety of cellular and humoral reactions entirely comparable to those recognized in the disease itself. An application of these data may now make for a highly increased sensitivity of appraisal of clinical disease, and provide the basis for prognosis and for estimating the effectiveness of various therapeutic measures. Lantern slides.

Paper No. 2—10:40 to 11:20

HEMATOLOGY—by B. K. Wiseman.

Recent carefully correlated studies of the pathologic changes that occur in the blood cells and fixed tissues during tuberculous pulmonary infection have resulted in a renewed appreciation of the present importance of the observed hematologic fluctuations occurring during the course of this disease. With the accurate identification of the formed elements of the blood, and the competent interpretation of their changes, it is believed that important additional data bearing on the diagnosis, clinical management and prognosis of pulmonary tuberculosis is now available. The relative significance of both qualitative and quantitative variations in the red blood cells and hemoglobin, the granular cells, monocytes and particularly the lymphocytes, will be emphasized and illustrated by presentation of data obtained in the study of medical and surgical cases of this disease. Lantern slides.

Paper No. 3—11:20 to 12:00

COLLAPSE THERAPY FOR PULMONARY TUBERCULOSIS by George M. Curtis.

The indications, for different available collapse procedures, are varied and are best individualized after a thorough investigation of the patient. Pneumothorax, phrenic nerve interruption, thoracoscopy with apicolysis and thoracoplasty, each produce collapse by differing methods with correspondingly varied end results. As a consequence the choice of one or more of the available operations is based upon a number of considerations.

Surgical collapse therapy, while yielding better results in unilateral disease, may be conservatively applied in the management of definite bilateral involvement. The vital capacity is an important consideration. Intranasal oxygen is an important postoperative adjunct in the management of anoxemia. The results obtained yield hope in the control of advanced pulmonary tuberculosis. Lantern slides.

Sixth Session

Friday, October 5, 2:15 P. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

CLINIC ON CHRONIC ARTHRITIS—by Russell L. Cecil, New York City.

Chronic arthritis is usually classified into two forms —the hypertrophic or osteo-arthritis and infectious or rheumatoid arthritis.

Description of each type.

Hypertrophic arthritis is generally looked upon as a senescent process which may or may not give rise to symptoms. The latter are usually brought on by some form of trauma.

Most authorities now look upon rheumatoid arthritis as a chronic infection complicated by important allergic factors. It bears many similarities to rheumatic fever, and like rheumatic fever is looked upon in many quarters as a streptococcal infection.

Rheumatoid arthritis is closely related to focal infection. Nearly all patients with rheumatoid arthritis give a history of focal infection either in the remote or immediate past.

The clinical picture of hypertrophic arthritis differs sharply from that of rheumatoid arthritis.

Description of each syndrome.

Demonstration of patients, illustrating each type. Lantern slide demonstration.

The modern treatment of chronic arthritis of the hypertrophic form consists of physiotherapy, hydrotherapy and regulation of the diet.

The modern treatment of rheumatoid arthritis is never limited to any one single therapeutic procedure, but aims to build up the patient in every way. In other words, we can hardly hope to cure a patient with rheumatoid arthritis by physiotherapy alone, or by vaccine alone, or by treating the intestinal tract alone, but these various methods, when combined, often produce excellent results.

The treatment of rheumatoid arthritis varies somewhat with the stage of the disease:

a. Early cases.
b. Active febrile cases.
c. Chronic well-established cases.
d. Advanced cases with marked ankylosis and deformity.

Seventh Session

Friday, October 5, 3:30 P. M.

FINAL SESSION OF THE HOUSE OF DELEGATES—ANNUAL ELECTION

(See detailed program and order of business)

Eighth Session

Friday, October 5, 6:30 P. M.

BANQUET

Banquet under direction of Entertainment Committee, R. G. Means, Chairman.

Address: by Gus W. Dyer, Nashville, Tenn. Professor Political Science, Vanderbilt University.

Ninth Session

Saturday, October 6, 9:00 A. M.

DISCUSSION OF GASTRO-INTESTINAL DISEASES—by prominent out-of-state speaker.

HOUSE OF DELEGATES

First Session

Thursday, October 4, 9:00 A. M.

Meeting Place—Junior Ballroom, northeast corner, Mezzanine Floor, Neil House.

In the chair, Verne A. Dodd, President of the Columbus Academy of Medicine.

Presentation of the President, C. L. Cummer.

House of Delegates Order of Procedure:

1. *Call to order by the President.*
2. *Roll Call.*
3. *Consideration of Minutes of previous meeting.* (Published in *The Journal*, October, 1933).
4. *Reports of Standing Committees:*

   (Reports submitted below, published in full in the October, 1934, *Journal).*

   (a) Public Policy—C. W. Stone, Cleveland, Chairman.
   (b) Medical Economics—J. Craig Bowman, Upper Sandusky, Chairman.
   (c) Publication—Andrews Rogers, Columbus, Chairman.
   (d) Medical Defense—J. E. Tuckerman, Cleveland, Chairman.
   (e) Medical Education and Hospitals—Ben R. McClellan, Xenia, Chairman.
   (f) Auditing and Appropriations—B. J. Hein, Toledo, Chairman.
5. *Reports of Special Committees:*

   (a) Preventive Medicine and Periodic Health Examinations—V. C. Rowland, Cleveland, Chairman.
   (b) Military and Veterans' Affairs—Louis Feid, Jr., Cincinnati, Chairman.
6. *Report of Officers:*

   (a) Treasurer's report combined with report of Committee on Auditing and Appropriations.
   (b) Reports of Councilors as to the condition of the societies in their respective districts.
7. *Appointment of Committees:*

   (a) A Committee on the Addresses of the President and President-Elect.
   (b) A Committee on Resolutions.
   (c) A Committee on Annual Reports.
   (d) A Committee on Credentials of Delegates.
   (e) A Committee of Tellers and Judges of Election.
8. *Nomination and Election of Nominating Committees:*

   (Nominations from the floor with one representative on the committee to be elected from each councilor district. This committee shall report to the second session on Friday afternoon, its recommendations in the form of a ticket, containing nominees for constitutional offices as required under the Constitution. The President will issue instructions to the committee on the constitutional requirements).

9. *Introduction of Resolutions.*

It is necessary that all resolutions introduced in the House of Delegates be referred to the Reference Committee on Resolutions and reported back to the House before action can be taken. All resolutions for consideration at this annual meeting must be introduced at this session and reported back to the House by the Reference Committee at the Friday afternoon session. All resolutions must be typewritten and submitted in duplicate.

10. *Miscellaneous Business.*

Second Session

Friday, October 5, 3:30 P. M.

Meeting Place—Junior Ballroom, northeast corner, Mezzanine Floor, Neil House.

1. *Roll Call.*

2. *Continuance of unfinished business from Thursday's session of the House of Delegates.*

3. *Annual Election.*

President-Elect. (One year). Nominations from the floor).

4. *Report of Nominating Committee.*

(a) Treasurer (three year term)—present incumbent, James A. Beer, Columbus.

(b) *Election of Members of Council.*

Members of Council are elected for two-year terms, those representing odd numbered districts expiring in even numbered years. To be elected:

Councilor, First District—Present incumbent, Parke G. Smith, Cincinnati.

Councilor, Third District—Present incumbent, O. P. Klotz, Findlay.

Councilor, Fifth District—Present incumbent, H. V. Paryzek, Cleveland.

Councilor, Seventh District—Present incumbent, E. B. Shanley, New Philadelphia.

Councilor, Ninth District—Present incumbent, I. P. Seiler, Piketon.

(c) *Election of Delegates and Alternates to the American Medical Association.*

Four delegates and their respective alternates. (Two years each).

Those whose terms expire at this time are:

Wells Teachnor, Sr., Columbus.
Carl R. Steinke, Akron. (Alternate).
Ben R. McClellan, Xenia.
A. C. Messenger, Xenia. (Alternate).
E. R. Brush, Zanesville.
A. Howard Smith, Marietta. (Alternate).
C. W. Stone, Cleveland.
C. L. Cummer, Cleveland. (Alternate).

(The By-Laws of the American Medical Association provide: A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve. Delegates and Alternates from constituent associations entitled to more than one representative shall elect them so that one-half as near as may be, shall be elected each year).

5. *Reports of Reference Committees.*

(a) Committee on Addresses of President and President-Elect.
(b) Committee on Annual Reports.
(c) Committee on Resolutions.

6. *Selection of place for Annual Meeting in 1935.*

7. *Miscellaneous Business.*

8. *Installation of Officers for 1934-1935.*

9. *Confirmation by House of Delegates of Committee Appointments announced by the newly-installed President, John A. Caldwell.*

(a) One member of the Committee on Public Policy. (Three years). (Member whose term expires, J. H. J. Upham, Columbus).

(b) One member of the Publication Committee. (Three years). (Member whose term expires, Andrews Rogers, Columbus).

(c) One member of the Committee on Medical Defense. (Three years). (Member whose term expires, J. E. Tuckerman, Cleveland).

(d) One member of the Committee on Medical Education and Hospitals. (Three years). (Member whose term expires, Ben R. McClellan, Xenia).

(e) One member of the Committee on Medical Economics. (Three years). (Member whose term expires, A. B. Brower, Dayton).

10. *Unfinished Business.*

11. *Final Adjournment of House of Delegates.*

MEDICAL SECTION

CECIL STRIKER, Cincinnati.....Chairman
HARRY W. GAUCHAT, Canton.....Secretary

First Session

Thursday, October 4, 2:15 P. M.

Meeting Place—Junior Ballroom, northeast corner, Mezzanine Floor, Neil House.

Paper No. 1—2:15 to 2:30

TREATMENT OF DIABETES IN CHILDREN—by Morris Deitchman, Youngstown.

The heredity of Diabetes has been established as a Mendelian recessive. Although insulin has greatly increased the expectancy of the diabetic child, it has also enabled the diabetic mother to reproduce her diabetes, as she can now carry her pregnancy to term. Under properly controlled conditions, these diabetic children can be made to live comparatively normal lives. Proper care during infection, adequate diet and insulin, and adherence to the requirements of normal child development are essential. Lantern slides.

Discussion—2:30 to 2:35—Henry John, Cleveland.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

CLINICAL SIGNIFICANCE OF ACHLORHYDRIA—by C. D. Christie, Cleveland.

Achlorhydria is a common clinical finding often in otherwise apparently normal people, but oftener still in people who are ill with various clinical manifestations. The frequency with which we find achlorhydria associated with definite deficiency states, and other conditions in which deficiency has not yet been proven, would seem to warrant the assumption that the relationship is more than casual.

It should always be suspected in individuals with most deficiency states, as pernicious anemia, microcytic anemia, pellagara, scurvy and sprue, but more particularly in individuals who manifest none of these clinical states, but who complain of no appetite, weight loss, general asthenia, sore tongue, looseness of the bowels, etc., and also in chronic atrophic arthritis.

Discussion —3:00 to 3:05—W. H. Bunn, Youngstown.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

TULAREMIA—by Lee Foshay, Cincinnati.

Specific antiserums appear to be the most effective therapeutic agents in acute human tularemia. 260 cases of tularemia have been treated with antiserums prepared from both the goat and the horse. Best responses are obtained when patients are treated early in the disease; the optimal time is before the twelfth day of illness. Tularemic sepsis, the only constantly fatal complication, seldom occurs before this stage. Out of 250 patients who were given serum before sepsis had occurred, there were no deaths. Comparison of data from untreated and from serum treated cases shows that antiserum diminishes the duration of disease, of adenopathies, of disability and of hospitalization period by at least 50 per cent. Lantern slides.

Discussion—3:30 to 3:35—Walter M. Simpson, Dayton.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

PRACTICAL OPHTHALMOSCOPY—by W. C. Davis, Columbus.

Introduction, description and definition.
Preparation of patient.
Different methods of Ophthalmoscopy, direct and indirect.
Kinds of Ophthalmoscopes.
Position of patient.
Some of the more important conditions to be looked for and diagnosed.

Discussion—4:00 to 4:05—C. L. Minor, Springfield.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

CHRONIC ULCERATIVE COLITIS—by H. F. Howe, Toledo.

Ulcerative colitis is a systemic disease with local manifestations in the colon.

Primary ulceration may be associated with generalized infection as an upper respiratory infection or food poisoning. A high percentage of cases occur in individuals with dysfunction of vegetative nervous system. Chronic spastic constipation important as an etiological factor. Etiological agent in a high percentage of cases the diplostreptococcus of Bargen.

An understanding of the pathological anatomy of this not uncommon disease helps its recognition and rational treatment. A high percentage of cases can be made symptoms free by a combination of general and specific measures including vaccine, serum, and intravenous chemicals. Lantern slides.

Discussion—4:30 to 4:35—Stewart Henderson, Akron.

General Discussion—4:35 to 4:45.

Selection of Nominating Committee.

Second Session

Saturday, October 6, 10:00 A. M.

Meeting Place—Junior Ballroom, northeast corner, Mezzanine Floor, Neil House.

Paper No. 1—10:00 to 10:15

SUB-OCCIPITAL OR CISTERN PUNCTURE—D. J. Kindel, Cincinnati.

A brief review of the anatomy of the sub-occipital region and cysterna magna—the indications for cistern puncture as routine procedure—advantages over lumbar tap—equipment required—the method and variations in technique—contra-indications—results of more than three hundred punctures—illustrated.

Discussion—10:15 to 10:20—Donald C. Bell, Cleveland.

General Discussion—10:20 to 10:30.

Paper No. 2—10:30 to 10:45

AMBULATORY TREATMENT OF RHEUMATIC HEART DISEASE—by Albert Kuhl, Dayton.

Definition of ambulatory case.
Classification of cases frequently mismanaged.
a. Undiagnosed cases with rheumatic history.
b. Properly diagnosed cases.
c. Interpretation of cardiac murmurs.
Treatment
Estimate of functional capacity
Regulation of exercise
Occupational therapy.
Diet
Written instructions.
General hygienic measures.
Drugs
Digitalis
Sedatives and hypnotics
Antianaemic factors
Diuretics.
Lantern slides.

Discussion—10:45 to 10:50—V. C. Rowland, Cleveland.

General Discussion—10:50 to 11:00.

Paper No. 3—11:00 to 11:15

HYPOCHROMIC ANEMIA—by R. L. Haden, Cleveland.

A hypochromic anemia is one in which the amount of hemoglobin per cell is less than normal or the amount per unit volume of cells is less than normal if the size of the mean erythrocyte is greater than normal. Thus, there are three types of hypochromic anemia: 1. With a high volume index and lower color index although this may be greater than 1.00. 2. With a normal volume index and low color index. 3. With a low volume and color index.

Hypochromia is probably always a direct result of an iron deficiency resulting from too low an intake, an increased loss by chronic hemorrhage or a disturbed utilization. An iron deficiency is indicated by a low color, volume or saturation index.

The most common type of hypochromic anemia is that due to chronic hemorrhage, although any factor which may cause an anemia may produce hypochromia. The anemia of infants fed exclusively on milk represents a deficiency in intake. Lantern slides.

Discussion—11:15 to 11:20—A. B. Brower, Dayton.

General Discussion—11:20 to 11:30.

Paper No. 4—11:30 to 11:45

MEASUREMENTS OF RENAL FUNCTION—by George I. Nelson, Columbus.

The clinical value of a renal function test depends not only on its theoretical accuracy but on its simplicity and the ease with which disturbing factors may be controlled. Of the numerous tests for renal function which have been devised, those in widest clinical use are the phenolsulphophthalein, the indigo carmine, the concentration and dilution, the urea clearance and the nitrogen containing substances excreted by the normal kidneys. For the average ambulatory non-edematous patient who is not hospitalized, the phenolsulphophthalein test seems to give the most constant and satisfactory results. For the hospitalized patient when water intake can be satisfactorily controlled, the concentration and dilution tests give more satisfactory and accurate results. The urea clearance test is extremely valuable in this type of patient and gives additional information. Only complete renal failure as shown by increase in non-protein-nitrogenous content of blood stream can be determined but lesser degrees cannot be detected.

Discussion—11:45 to 11:50—S. A. Hatfield, Columbus.

General Discussion—11:50 to 12:00.

Paper No. 5—12:00 to 12:15

THE CLINICAL PICTURE OF BRIGHT'S DISEASE—by S. D. Simon, Cincinnati.

The common forms of Bright's Disease are described according to a simple classification and an attempt is made to demonstrate the reasonableness of this point of view. Bedside observation and careful examination of the urine furnish adequate data for differential diagnosis in the vast majority of cases. Treatment is outlined according to general physiological principles as modified by the individual case. In general, the diagnosis and therapeutic facilities of the general practitioner are kept constantly in mind.

Discussion—12:15 to 12:20—Louis A. Levison, Toledo.

General Discussion—12:20 to 12:30.

Election of Officers.

SURGICAL SECTION

NORRIS W. GILLETTE, Toledo.....Chairman
VERNE A. DODD, Columbus.....Secretary

First Session

Thursday, October 4, 2:15 P. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

Paper No. 1—2:15 to 2:30

ACUTE EMPYEMA—by Carl R. Steinke, Akron.

1. Comparison of results in 138 adult cases with 329 in children.
2. Short review of literature
3. Type of operation used
4. Types of organisms cultured from pus
5. Number of cases in each age group
6. Mortality consideration.

Lantern slides.

Discussion—2:30 to 2:35—Dudley Palmer, Cincinnati.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

THE TREATMENT OF BENIGN UTERINE BLEEDING—by Louis Feid, Jr., Cincinnati.

Benign uterine hemorrhage is a term that has come into common usage during the past decade. It is applied to all of the metrorrhagias and menorrhagias if malignancy and pregnancy be excluded.

Abnormal bleeding from the uterus is a symptom and not a disease and the precise etiology must be determined in order that the condition be successfully controlled. This study consists of an analysis of the cases of benign uterine hemorrhage that have been treated since 1927.

It is essential that a thorough general examination of the patient together with tissue diagnosis of the uterine scrapings be made.

The use of Radium as a specific in the benign hemorrhage of the menopause is stressed.

Discussion—3:00 to 3:05—Emil R. Swepston, Cincinnati.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

MANAGEMENT OF COMMON DUCT STONE AND OBSTRUCTION—by Fred M. Douglass, Toledo.

Review of 100 cases
Pre-operative management
Type of operation in selected cases

Post-operative care and study of biliary tree with the aid of an opaque medium is important in the prevention of post-operative symptoms, and aids in the early diagnosis of an over-looked stone.

Two step procedure offers a reduction in mortality in a certain group of cases.

Analysis of end results. Lantern slides.

Discussion—3:30 to 3:35—Elmer R. Arn, Dayton.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

SAFETY FACTORS IN INTESTINAL SURGERY—by Fred Fletcher, Columbus.

The writer recognizes the importance of pre and post-operative preparation, but deals principally with technical features, which experience has shown are "safety" factors in the mechanical management of gastro-intestinal lesions.

Discussion—4:00 to 4:05—Frederick C. Herrick, Cleveland.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

ASEPTIC URETERO-INTESTINAL ANASTOMOSIS—by Charles C. Higgins, Cleveland.

An operation for aseptic uretero-intestinal anastomosis is described which can be performed bilaterally in one procedure without interruption of kidney function. The continuity of the ureter is not severed and normal physiologic activity of the kidney and ureter is not disturbed until the new channel is established between the ureter and the bowel. Urinary obstruction does not occur and infection is negligible. The valve principle is utilized, eliminating subsequent complications of the upper urinary tract.

The immediate results in a series of clinical cases have been most gratifying, and the procedure has proved practicable in the hands of several different surgeon. Lantern slides.

Discussion—4:30 to 4:35—Wm. N. Taylor, Columbus.

General Discussion—4:35 to 4:45.

Selection of nominating committee.

Second Session

Saturday, October 6, 10:00 A. M.

Meeting Place—Main Ball Room, northwest corner, Mezzanine Floor, Neil House.

Paper No. 1—10:00 to 10:15

PROBLEMS IN TREATMENT OF FRACTURES OF UPPER EXTREMITY—by Walter Hoyt, Akron.

Discussion of end results of fractures of the upper extremity with special reference to bad results and complications. Attempt is made to show some of the causes of bad end results and their prevention.

Treatment of the complications will be discussed. Lantern slides.

Discussion—10:15 to 10:20—Clarence H. Heyman, Cleveland.

General Discussion—10:20 to 10:30.

Paper No. 2—10:30 to 10:45

HYPERTHYROIDISM—Harry G. Sloan, Cleveland.

Prefer the term "thyroid crisis" as we know from blood iodin studies that blood iodin is reduced following bilateral lobectomy.

Postoperative thyroid crisis is seen most frequently in the older individuals where their disease has been of several years' standing with marked weight loss.

The body is acutely deprived of the secretion of thyroid by thyroidectomy. This is comparable to the crisis seen in removal of an adenoma of the parathyroid causing acute tetany, and also the crisis seen on removal of an adenoma of the adrenal cortex. In all three instances the reaction can be mitigated by substitution of the active principle of the gland involved.

Discussion—10:45 to 10:50—George M. Curtis, Columbus.

General Discussion—10:50 to 11:00.

Paper No. 3—11:00 to 11:15

THE GENERAL TREATMENT OF THE CANCER PATIENT WITH SPECIAL EMPHASIS UPON MAINTAINING THE NORMAL BLOOD PICTURE—by Kelley Hale, Wilmington.

The general treatment of cancer has been greatly neglected in the past. It is our practice to keep our cancer patients under regular and systematic observation for the rest of their lives or while they remain in our territory.

Periodic examination of cancer patients following operation or radiation inspires the confidence of the patient and in turn is conducive to a more normal psychological state. To some of our patients who have a tendency toward mental depression, we suggest a game which will prove that health is more fatal than cancer. From then on we ask them to keep account of the number of people who die who are in apparently good health.

The cachexia or secondary anemia in cancer patients can now be controlled in most patients thus prolonging the life of the patient, at times in a state of excellent well being thus greatly increasing the time for the local treatment of the disease.

The internist should be utilized in the treatment of cancer and should be stimulated to study and treat this disease from the medical standpoint. It should be understood that general treatment of the cancer patient is not for the cancer. The cancer patient responds well in a general way to the treatment employed for pernicious anemia.

Discussion—11:15 to 11:20—Dudley Palmer, Cincinnati.

General Discussion—11:20 to 11:30.

Paper No. 4—11:30 to 11:45

NEOPLASMS OF THE BREAST—by W. A. Neill, Toledo.

Pathological classification of neoplasms, simplified for a practical surgical working basis, suggesting certain short cuts and slight additions to the "Cheatle and Cutler" plans. Presentation is to be shown by micro-pathological slides—differentiation of the physiological from the pathological breast—special emphasis being placed on the diagnosis, and the surgical management of these conditions. Special surgical armamentarium, including operating room sec-

tions and a competent pathologist's services. Summary of cases and cures, a plea being entered for a more concerted effort on the part of surgeons and pathologists for tumor registration. Dissemination of Lay literature and a closer cooperation between the general practitioner and surgeon in diagnosis and treatment of early cases.

Discussion—11:45 to 11:50—L. G. Bowers, Dayton.

General Discussion—11:50 to 12:00.

Paper No. 5—12:00 to 12:15

TECHNIQUE FOR INTESTINAL ANASTOMOSIS—by Charles T. Souther, Cincinnati.

Special emphasis on giving proper regard for blood supply; theory promulgated by Byron H. Robinson of Chicago about 1906.

Special regard for leaving the stoma as wide or wider than the normal diameter of the intestine, a technique especially adopted to uniting small or large bowel end to end, or small bowel end to end, and can be applied with end to side technique, indicated in any type of resection at any level. Has been used by me now for twenty years; can be used best with clamps, and preferably of the angeotribe type. Lantern slides.

Discussion—12:15 to 12:20—Ralph Good, Cincinnati.

General Discussion—12:20 to 12:30.

Election of Officers.

OBSTETRICS AND PEDIATRICS

JOHN TOOMEY Cleveland.....Chairman
J. K. HOERNER, Dayton.....Secretary

First Session

Thursday, October 4, 2:15 P. M.

Meeting Place—Green Room (Main Dining Room) northwest corner, Lobby Floor, Neil House.

Paper No. 1—2:15 to 2:30

THE PROBLEM OF THE STILLBORN—by Walter W. Brand, Toledo.

Chief causes of foetal death may be divided into primary causes and consequent factors. Observation shows that there are more foetal deaths from complications of labor than during pregnancy from maternal or placental disease. The prevention of foetal death—a more thorough examination during the ante and intra natal periods, with the application of corrective procedures by the obstetrician.

Discussion—2:30 to 2:35—A. J. Skeel, Cleveland.

General Discussion—2:35 to 2:45

Paper No. 2—2:45 to 3:00

WOMEN'S CONTRIBUTION TO THE REDUCTION OF MATERNAL MORTALITY—by Mabel E. Gardner, Middletown.

Progress made so far in reduction of death rate. Necessity now of educating women to recognize need of prenatal care and seek it early. This can best be done by women. What is being done; Maternal Health Booth at Century of Progress; Public Health Federation's Maternal Health education campaign in Cincinnati, Illinois State Medical Association Committee of 1933, etc. Possibility of extending these advantages and organizing a state-wide education campaign in Ohio.

Discussion—3:00 to 3:05—Helena T. Ratterman, Cincinnati.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

CLINICAL ASPECTS OF ALKALOSIS—by J. Hart Davis, Cleveland.

There are three clinical origins of alkalosis:
1. Loss of chloride by vomiting
2. Loss of carbonic acid (CO_2) by hyperventilation
3. The excessive ingestion of bicarbonate.

Blood chemical estimations will give adequate information in all such cases but these are often impracticable at the bedside. There are two clinical symptoms, however, which, if looked for, will give bedside help in the absence of chemical studies:
1. Slow, shallow respiration with period of apnoea
2. Tetany with rigidity and convulsions.

Inasmuch as alkalosis occurs regularly with pyloric obstruction or other "high" intestinal obstruction, it is possible to use observations of the respiratory rate to help in localizing the site of obstruction, since in "low" obstruction as in intussusception, chlorides are absorbed before vomiting occurs and alkalosis is mild or negligible.

The common practice of giving bicarbonate water by mouth in all cases of vomiting is condemned and the substitution of dextrose solution, Karo water, or sweetened orange juice is advised. Lantern slides.

Discussion—3:30 to 3:35—Wallace B. Taggart, Dayton.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

THE CLINICAL RELATIONSHIP BETWEEN COLOR OF NASAL SEPTUM AND VARIOUS BIOCHEMICAL AND ENDOCRINE STATES IN CHILDREN—by Stanley D. Giffen, Toledo.

The primary observation of Dr. Jarvis and Dr. Stuckey.

The observations of a group of fifty physicians interested in this study.

The relationship between the color of the nasal septum and the character of the diet, various chemical balances within the body, the balance between the sympathetic and para-sympathetic divisions of the autonomic nervous system and also between certain endocrine secretions.

Clinical correlations are pointed out between these findings and various disease groups and bodily states found in children. Brief illustrative case histories.

Attempt to evaluate this added clinical approach to the understanding and treatment of disease in children. Lantern slides.

Discussion—4:00 to 4:05—Elmer G. Horton, Columbus.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

CONVULSIONS IN INFANCY—by John E. Brown, Jr., Columbus.

Approximately 2300 consecutive admissions to the Infant's Hospital of Boston, Massachusetts, over a period of 39 months have been reviewed. In this series, 400 cases under two years of age were found with a history of convulsions immediately preceding entry or during their hospital stay. These have been classified as to date of onset of the first convulsions, etiological factors, and a statistical study made. Lantern slides.

Discussion—4:30 to 4:35—J. E. McClelland, Cleveland.

General Discussion—4:35 to 4:45.

Second Session

Saturday, October 6, 10:00 A. M.

Meeting Place—Green Room (Main Dining Room) northwest corner, Lobby Floor, Neil House.

Paper No. 1—10:00 to 10:15

THE ADVANTAGES AND USES OF THE ELASTIC BAG IN THE MANAGEMENT OF LABOR—by Henry L. Woodward, Cincinnati.

The elastic bag is a more effective dilator than the non-elastic one.

Its use in the induction of labor.

Its use as a dilator when the membranes have ruptured prematurely, especially in malpositions of the foetus; occiput posterior, breech, shoulder and face presentations.

Its use as a dilator when the cervix is rigid, and in the presence of minor degrees of disproportion.

Its use in prolapse of the cord.

Its use in antepartum hemorrhage especially, Placenta Previa.
Its dangers.

Discussion—10:15 to 10:20—W. D. Porter, Cincinnati.

General Discussion—10:20 to 10:30.

Paper No. 2—10:30 to 10:45

THE INFLUENCE OF THE UPRIGHT POSITION ON PREGNANCY AND PARTURITION—by Andrews Rogers, Columbus.

The effect of intra-abdominal pressure upon the ureters accompanied by back pressure in upper urinary tract and kidneys—upper urinary tract infection (pyelitis) known to follow and so the possibility of a positive etiological factor for late toxemia (pre-eclampsia and eclampsia).

The effect of the rise of the fundus from below interfering with the descent of the diaphragm causing a diminished air intake and hence a lower oxidizing power when oxidizing needs are greatest. Another possible positive etiological factor in later toxemia.

The effect of the displaced heart in later pregnancy, due to the rise of the fundus, and the consequent circulatory modifications due to this in liver, kidney, brain and elsewhere, and so also a possible etiological contribution to later toxemia.

The effect of the modified pelvic girdle and the loss of the powerful caudel appendage muscle upon parturition.

Discussion—10:45 to 10:50—S. J. Goodman, Columbus.

General Discussion—10:50 to 11:00.

Paper No. 3—11:00 to 11:15

POSTPARTUM MATERNAL CARE—by W. D. Fullerton, Cleveland.

Postpartum maternal care should begin as soon as the child is born. The immediate attention to the cervix and perineum, as well as their later care, is discussed. Stress is laid on such care being the best prophylaxis against the development of cancer in the location at a later date. Misplacements of the uterus and their prevention are given consideration.

The general and special care advisable for the mother in both normal and abnormal conditions is outlined, with special emphasis on care of the bladder, bowels, breasts, and her physiological requirements.

Discussion—11:15 to 11:20—W. R. Barney, Cleveland.

General Discussion—11:20 to 11:30.

Paper No. 4—11:30 to 11:45

OUR RESPONSIBILITY TO THE NEWBORN—by Sterling H. Ashmun, Dayton.

Statistics establish the fact that medical care has lessened the morbidity and mortality of childhood, but has not lessened the mortality of the neonatal period. There should be less still births and less deaths during the first few days of life.

There are many conditions of the newborn that may be better understood by more careful and painstaking study and still other conditions exist for which we still have little to offer, but an explanation.

Brief case reports will illustrate the differential. diagnosis and treatment of birth injury, atelectasis, asphyxia, amniotic pneumonia, mediastinal pressure and germ cell deficiencies. Lantern slides.

Discussion—11:45 to 11:50—Robert A. Lyon, Cincinnati.

General Discussion—11:50 to 12:00.

Paper No. 5—12:00 to 12:15

OBSERVATIONS ON THE GROWTH AND STATE OF NUTRITION OF PREMATURE INFANTS FED ON ANTI-RACHITIC AND ANTI-SCORBUTIC FOOD—by A. J. Horesh, Cleveland.

An analysis and evaluation of clinical results obtained in a series of premature infants fed an antirachitic and antiscorbutic food is presented. The study was carried out in an institution where all conditions of care and surroundings were uniform. Whenever possible, each infant was observed for at least six months. Data are summarized with respect to the following: Average daily gain in weight, muscular development, general state of nutrition, frequency and character of the stools, appetite and incidence of gastro-intestinal upsets, respiratory infections, anemia and rickets. Lantern slides.

Discussion—12:15 to 12:20—Wm. D. Lyon, Akron.

General Discussion—12:20 to 12:30.

Election of Officers.

EYE, EAR, NOSE AND THROAT

IVOR G. CLARK, Columbus.....Chairman
ORVILLE J. WALKER, Youngstown.....Secretary

First Session

Thursday, October 4, 2:15 P. M.
Meeting Place—Red Room, southwest corner, Mezzanine Floor, Neil House.

Paper No. 1—2:15 to 2:30

SURGICAL TREATMENT OF TRACHEO-BRONCHIAL DIPHTHERIA—by J. D. Fouts, Dayton.

The mortality for years in this disease has been exceedingly high. Intubation and tracheotomy in many cases have been unsatisfactory. Aspiration of trachea and bronchi gives better results. In a few cases membrane may be removed by foreign body forceps. A direct laryngoscopic examination is a great aid to differential diagnosis. The mortality has been low with no complications, due directly to surgical manipulation. Lantern slides.

Discussion—2:30 to 2:35—Edward King, Cincinnati.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

CANCER OF THE ESOPHAGUS—by Fred W. Dixon, Cleveland.

Cancer of the esophagus is a fairly common occurrnce. There are two types: Sarcoma (rare) and Carcinoma (common). Regarding the etiology, the foremost theory is that it results from chronic irritation. Carious teeth seem to be a factor. The location is usually at end of the constrictions. In a review of 3248 cases, 22 per cent were found in the upper third, 36 per cent in the middle third while 42 per cent were in the lower third. The earliest symptom is a sense of fullness behind the sternum. The greatest hope in treatment is in early diagnosis. Here radium seeds or radical surgery may be helpful. In the late stages, dilation or gastrotomy may bring comfort and prolong life. Every patient over 40 presenting symptoms of dysphagia, substernal or interscapular pain, regurgitation of food, should be suspected of having cancer until proven otherwise. Lantern slides.

Discussion—3:00 to 3:05—L. L. Deeton, Cleveland.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

CHRONIC NASAL SINUSITIS, EVALUATION OF OPAQUE OILS IN DIAGNOSIS AND TREATMENT. SOME SURGICAL OBSERVATIONS AND RESULTS—by Henry M. Goodyear, Cincinnati.

The importance of position in making roentgenograms with opaque oils. Relative importance side and front views of antrums. Of what use and what sort of oil shall we use in treatments. Surgical observations. Lantern slides.

Discussion—3:30 to 3:35—H. G. Beatty, Columbus.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

COMPLICATIONS OF MASTOIDITIS—by W. H. Evans, Youngstown.

The symptomatology, diagnosis and treatment of affections of the labyrinth, secondary to acute and chronic infections of the middle ear and mastoid with case reports. Stressing the importance of repeated

white and differential blood count in the intelligent management of this condition. A brief discussion of involvement of abducens nerve secondary to otitic infection with case report of the condition. Lantern slides.

Discussion—4:00 to 4:05—Russell G. Means, Columbus.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 5:15

MENIERE'S SYMPTOM COMPLEX. MEDICAL TREATMENT—by A. C. Furstenberg, Ann Arbor, Michigan—GUEST SPEAKER.

The therapeutic management of this malady has been for many years a controversial matter and one in which a confusing number of remedies have been offered based chiefly upon the hope that they might influence some of the many hypothetical pathological changes which are assumed to exist. Some of the treatment appear to have merit although the lack of sustained practicability of medical therapy is constantly in evidence.

A simple glossary will suffice to enumerate and place on record the symptoms which characterize the disease as it is treated in the following studies. A violent attack of vertigo in a patient with unilateral deafness; occasionally impaired cochlear function on both sides more profound in the ear to which the symptoms are referred; nausea, vomiting and spontaneous nystagmus in the severe seizures; persistent tinnitus—often unilateral—increased during the paroxysm; labyrinthine tests of little significance—usually within the limits of normal; a pathetic picture of total disability in an individual suffering from a veritigenous attack or living in the terror of an impending one.

The treatment herein recommended was evolved from a technical study of water exchange. This investigation revealed biochemical changes which suggested a new concept in the therapeutics of this disease. The latter is discussed in detail.

Second Session

Saturday, October 6, 10:00 A. M.

Meeting Place—Red Room, southwest corner, Mezzanine Floor, Neil House.

Paper No. 1—10:00 to 11:00

RECENT ADDITIONS TO THE CLINICAL STUDY OF INTRAOCULAR PRESSURE AND GLAUCOMA—by Mark J. Schoenberg, New York—GUEST SPEAKER.

I. Introductory Remarks.

II. The Intraocular Tension.

Its relation to: a) general blood pressure; b) local blood pressure; c) capillary permeability; d) physico-chemical conditions in the blood; e) the function of the internal secretory organs and vegetative nervous system; (f) about the mechanism balancing or regulating the intraocular pressure.

III—Glaucoma.

A) The study of the 24 hour ocular curve.

B) Recent and New Diagnostic Tests.

The Provocative Tests: a) The dark light test; b) The coffee test; c) The jugular venous flow interference test; e) The adrenaline test.

Paper No. 2—11:15 to 11:30

MANAGEMENT OF STRABISMUS—by Robert F. Thaw, Akron.

Emphasizing the extreme importance of early correction in these cases, especially early operation in the alternating type; demonstrating technique that the author has found to greatly simplify the operation in very young patients, which considerably reduces the hazards of so many other operations such as over correction, under correction, and infection. Lantern slides.

Discussion—11:30 to 11:35—A. L. Brown, Cincinnati.

General Discussion—11:35 to 11:45.

Paper No. 3—11:45 to 12:00

POSTOPERATIVE TREATMENT OF CATARACT—by A. B. Bruner, Cleveland.

The paper presents the author's usual method of treatment of cataract from the time the operation is completed until the patient leaves the hospital. He describes in detail the type of dressing, local medicinal agents and management of the patient. The paper is completed by a summary of the more common postoperative complications with brief directions for their treatment.

Discussion—12:00 to 12:05—John E. L. Keyes, Youngstown.

General Discussion—12:05 to 12:15

Election of Officers.

NERVOUS AND MENTAL DISEASES

HENRY C. SCHUMACHER, Cleveland.....Chairman
C. C. KIRK, Orient.....Secretary

First Session

Thursday, October 4, 2:15 P. M.

Meeting Place—Garden Room, south from Mezzanine Floor, Neil House.

Paper No. 1—2:15 to 2:30

THE REPRESENTATION OF VISCERAL FUNCTION IN THE BRAIN—by A. R. Vonderahe, Cincinnati.

In recent years there has been felt a need of further knowledge of the areas in the brain associated with visceral function. These centers act as coordinators of all internal glandular secretions, and play a role in the regulation of the metabolism of fat, carbohydrate, protein, salt and water. They appear to determine the patterns of emotional expression and to govern the sympathetic and parasympathetic influences on blood vessels, viscera, sweat and sebaceous secretion. Recent experimental work as well as clinico-pathologic studies on the diencephalon are adding to our knowledge of these areas of the nervous system. The anatomy, pathologic physiology and pathology of these areas are reviewed, and clinical cases are described. The paper is illustrated with lantern slides.

Discussion—2:30 to 2:35—Thomas A. Ratliff, Cincinnati.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00.

THE THYROID FACTOR IN MENTAL DISEASE—by N. W. Kaiser, Toledo.

The official classification of mental diseases recognizes the existence of psychoses due to the disorders of thyroid function and places them under the group of psychoses with somatic disease. In the routine admission of patients to the Toledo State Hospital, a rather high percentage of cases present clinical symptoms which at least suggest thyrotoxicosis. Autonomic nervous system disorders and certain types of functional psychoses, particularly the anxiety forms of psychoneuroses often present the clinical picture of thyrotoxicoses. The correct evaluation of the toxic thyroid as an etiological factor in the production of a psychosis is often a rather complex problem. The findings in connection with several hundred cases admitted to the Toledo State Hospital over a period of three or four years are discussed. Lantern slides.

Discussion—3:00 to 3:05—Norris Gillette, Toledo.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

TRAUMATIC NEUROSIS—by G. T. Harding III, Columbus.

Existing economic conditions superimposed on workmen's compensation legislation have multiplied

the frequency of that type of hysteria which we call traumatic neurosis.

The need for education of the profession in both the recognition and understanding of the condition is emphasized by the fact that practically every physician does some industrial work or is consulted by injured workmen.

Traumatic neurosis is no different from other psychoneuroses or hysterias and the same underlying principles of treatment, both preventive and curative apply.

The physician who exaggerates the seriousness, emphasizes the dangers, paints gloomy pictures for the future of an injury, is an all too frequent etiological factor. Careless remarks during the early period after injury defeat the injured man's personality in its attempt to meet new and trying situations created by the injury. The importance of educating the average doctor to understand the nature of a traumatic neurosis is apparent to all who have any contact with injured workmen.

Diagnosis, principles of treatment and management are discussed with case histories to illustrate.

Discussion—3:30 to 3:35—H. H. Drysdale, Cleveland.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

SOME UNUSUAL COMPLICATIONS IN MALARIAL THERAPY—by G. H. Williams, Jr., and L. J. Karnosh, Cleveland.

Out of a series of some 600 cases of central nervous system syphilis treated with benign tertian malaria, four died revealing unusual ulcers of the gastro-intestinal tract, two showed ruptured spleens, and one acute pneumococcus meningitis and vegetative endocarditis.

Lantern slides of some of the gross specimens and pathological tissues will be presented, in an attempt to explain the changes found at post-mortem examination.

Discussion—4:00 to 4:05—D. A. Johnston, Cincinnati.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

THE ROLE OF GLANDULAR THERAPY IN THE TREATMENT OF BEHAVIOR DISORDERS OF CHILDREN—by Louis A. Lurie, Cincinnati.

An analysis of the first thousand cases of behavior disorders of children studied at the Child Guidance Home shows that in nearly 10 per cent of the cases, glandular disturbances were the principal causative factors. This is a startlingly large percentage and points not only to the need of a routine endocrine study of every problem child, but also to the wide applicability and possibilities of endocrine therapy in the treatment of these cases.

Concrete examples illustrating both the method of treatment and the results are presented in the paper. Lantrn slides.

Discussion—4:30 to 4:35—J. V. Greenebaum, Cincinnati.

General Discussion—4:35 to 4:45.

Second Session

Saturday, October 6, 10:00 A. M.

Meeting Place—Garden Room, south from Mezzanine Floor, Neil House.

Paper No. 1—10:00 to 10:15

TRAUMATIC SUBDURAL HEMATOMA—A REPORT OF THIRTEEN CASES—by W. James Gardner, Cleveland.

This is a review of thirteen cases of traumatic subdural hematomas observed during the past four years. The similarity of the mode of onset and clinical course of these lesions is very striking. An hypothesis is advanced to explain the latent interval and the progressive behavior of these lesions. Lantern slides.

Discussion—10:15 to 10:20—Edson J. Emerick, Columbus.

General Discussion—10:20 to 10:30.

Paper No. 2—10:30 to 10:45

DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA AND SCHIZOPHRENIC REACTION TYPES—by J. F. Bateman, Cincinnati.

Our present day concept of schizophrenia is certainly a step forward from the rather meaningless connotation of dementia praecox. Although schizophrenia is too inclusive, it serves a useful purpose in classifying those bizarre mental reactions which cannot be placed in other groups.

Since all our diagnostic equipment is composed of psychological data only, it is the purpose of this paper to show two separate and rather distinct reactions based upon anatomical findings.

The schizophrenias and the schizophrenic reaction-types differ in cause and effect as well as their course and issue. The schizophrenic reaction-types are associated with very definite changes in the cranial division of the autonomic nervous system.

The differential is made from the cause, course and issue of the disease, with certain physical and neurological findings indicative of changes in the cranial division of the autonomic nervous system and adjacent structures of the diencephalon.

Discussion — 10:45 to 10:50 — Emerson North, Cincinnati.

General Discussion—10:50 to 11:00.

Paper No. 3—11:00 to 11:15

EPIDEMIC ENCEPHALITIS—by P. George Tait, Toledo.

Symptoms occurring in epidemic of 1918 and sporadically since and those occurring in epidemic of 1933 were similar in some respects, but varied in kind and degree in the different epidemics and also in the same epidemic.

Stages and manifestations of Encephalitis Lethargica

Symptoms in recent Epidemic Encephalitis B

Serological findings in different epidemics.

Reports of recent acute cases of Encephalitis and cases of Encephalitis Lethargica, showing different manifestations including cases of respiratory disorders and oculogyric crisis.

Etiology and treatment of Epidemic Encephalitis.

Discussion—11:15 to 11:20—Louis A. Miller, Toledo.

General Discussion 11:20 to 11:30.

Paper No. 4—11:30 to 11:45

EMOTIONAL STATES IN CHOREA—by O. B. Markey, Cleveland.

The importance of the affective state of the child suffering from Chorea seems at times to be greater than the symptoms referable to the organic nervous disorders. In a number of cases studied in the Mental Hygiene Clinic of Mount Sinai Hospital, the emotional relationship between the choreic and the home situation has been recognized and attacked by psychiatric and social work techniques. It will be shown that recurrences have frequently been motivated by the emotional needs of the child to whom the symptoms of Chorea have become a weapon against a too difficult reality. In some of these cases of course, the recurrence has not been true Chorea, but rather the development of functional signs more closely resembling habit spasms.

Discussion—11:45 to 11:50—Henry C. Schumacher, Cleveland.

General Discussion—11:50 to 12:00.

Paper No. 5—12:00 to 12:15

THE PHYSICAL BASIS OF HUMAN BEHAVIOR—by H. D. McIntyre, Cincinnati.

The paper is an attempt at the proper evaluation of the physical factors in behavior. A discussion is undertaken of the role of the sympathetic nervous system the extra-pyramidal system, and myelinization of the cerebral cortex as factors affecting behavior.

Discussion—12:15 to 12:20—L. J. Karnosh, Cleveland.

General Discussion—12:20 to 12:30.

Election of Officers.

PUBLIC HEALTH AND PREVENTIVE MEDICINE

R. H. MARKWITH, Akron.....Chairman
P. A. DAVIS, Akron.....Secretary

First Session

Thursday, October 4, 2:15 P. M.

Meeting Place—Colonial Room, south from Mezzanine Floor, Neil House.

Paper No. 1—2:15 to 2:30

THE PREVENTION AND TREATMENT OF DIPHTHERIA—by H. H. Pansing, Dayton.

1. No child need die of Diphtheria
2. How to prevent Diphtheria
   a. Natural immunity
   b. Degree of susceptibility
   c. Schick test and immunization
   d. Reports of actual work done and comparison of different methods used.
3. Treatment of Diphtheria cases
   a. Much depends upon early diagnosis
   b. Antitoxin and how administered to get best results.
   c. Control
   d. Resume of present knowledge that above statement may be realized.

Discussion—2:30 to 2:35—R. H. Markwith, Akron.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

THE PROBLEM OF PROLONGED DISABILITY IN INDUSTRIAL ACCIDENTS—by C. D. Selby, Toledo.

Analysis is made of prolonged disability and suggestions offered as to their reduction.

Discussion—3:00 to 3:05—W. E. Obetz, Columbus.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

MEDICO-LEGAL ASPECTS OF SILICOSIS—by Paul M. Holmes, Toledo.

Six states have made silicosis a compensable occupational disease. Several hundred suits are now pending in the Civil Courts in two of these states. It is apparent that there will be an enormous increase in this number as more states make this disease compensable. It would seem advisable for the medical profession to unite on some procedure relative to these suits. This paper offers some illustrations and suggestions.

Discussion—3:30 to 3:35—E. R. Hayhurst, Columbus.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

INDUSTRIAL ASPECTS OF ACUTE PERFORATION AND HEMORRHAGE OF PEPTIC ULCER—by A. J. Beams, Cleveland.

For the purpose of compensation, the question often arises whether certain kinds of work may be a factor in causing acute perforation or hemorrhage occurring in patients with peptic ulcer.

150 patients with peptic ulcer, of whom 50 had acute perforation and 100 had gross hemorrhage, were studied for the purpose of determining what might be the precipitating cause of perforation or hemorrhage.

Experiments were performed to show what effect certain types of work might have on peristalsis and tension of the stomach.

Results of these studies are fully discussed.

Lantern slides.

Discussion — 4:00 to 4:05 — Donald M. Glover, Cleveland.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

COMFORTABLE FEET FOR THE WORKER—by C. L. Ferguson, Portsmouth.

Much thought has been given to annual examinations, to the correction of vision, removal of foci of infection and improvement of working conditions but, little thought is given to the diagnosis and treatment of uncomfortable feet.

Discussion—4:30 to 4:35—P. A. Davis, Akron.

General Discussion—4:35 to 4:45.

Second Session

Saturday, October 6, 10:00 A. M.

MEETING Place—Colonial Room, south from Mezzanine Floor, Neil House.

Paper No. 1—10:00 to 10:15

TUBERCULOSIS IN CHILDREN IN RURAL LORAIN COUNTY—by Henry R. O'Brien, Oberlin.

A school tuberculosis survey was conducted with C. W. A. help; 2,500 Mantoux tests were made, and *X*-ray taken of most of the 400 reactors. Types of tuberculosis found. Treatment through family physician. Statistics. Lantern slides.

Discussion—10:15 to 10:20—H. G. Southard, Columbus.

General Discussion—10:20 to 10:30.

Paper No. 2—10:30 to 10:45

THE PROGRESS OF THE PERIODIC HEALTH EXAMINATION IN FRANKLIN COUNTY—by Louis N. Jentgen, Columbus.

The Columbus Academy of Medicine appointed a periodic health examination committee for a period of five years. As a member of this committee, we have gathered data from the experiences of other committees all over the country. Interesting data has been accumulated and this data, I wish to report to the association.

Discussion—10:45 to 10:50—Jonathan Forman, Columbus.

General Discussion—10:50 to 11:00.

Paper No. 3—11:00 to 11:15

HYPERTENSION WITH RELATION TO CAPACITY FOR WORK—by A. G. Cranch, Cleveland.

Frequency of hypertension among the industrially employed.

General significance of hypertension.

It is essentially a symptom; Importance must be estimated by associated conditions.

Difficulty in setting any standards.

Need for continued supervision of those showing marked tendency to hypertension.

Discussion—11:15 to 11:20—Don B. Lowe, Akron.

General Discussion—11:20 to 11:30.

Paper No. 4—11:30 to 11:45

THE PRESENT DAY CONCEPTION OF THE CANCER PROBLEM—by Andre Crotti, Columbus.

Discussion of the latest theories regarding the Etiology of Cancer.

Analogy between malignancies and chronic infections.

Fulminating malignancies sometimes simulate acute infections.

Discussion of the Cancer Problem from the standpoint of the Medical Profession and from the standpoint of the Laity.

Preventive measures and treatment of malignancies.

Discussion—11:45 to 11:50—H. L. Reinhart, Columbus.

General Discussion—11:50 to 12:00.

Paper No. 5—12:00 to 12:15

DEVELOPMENT OF PREVENTIVE MEDICINE—by Finley Van Orsdall, Columbus.

1. Comments on early medicine and the plagues afflicting mankind.
2. Quarantine as a preventive measure.
3. The dawn of preventive medicine.
4. The degenerative diseases; their relation to present living conditions and to the preventable diseases of childhood.
5. Public health and finances.
6. Status of preventive medicine today.

Discussion—12:15 to 12:20—O. L. Van Horn, Columbus.

General Discussion—12:20 to 12:30.

Election of Officers.

Eastern Standard Time

The time indicated on this program is Eastern Standard Time.

Essayists - Discussants

"All papers read before this Association shall be its property. Each paper shall be deposited with the Section Secretary when read. Authors shall not cause papers read before this Association to be published as original elsewhere, nor until after they have been published in the official *Journal* of this Association."—Chapter IV, Section 3, By-Laws.

Discussants of papers are requested to forward typewritten copies of their remarks to the *Ohio State Medical Journal*, 1005 Hartman Theater Building, Columbus, Ohio, not later than two weeks after the Annual Meeting in order that they may be published with the papers.

Registration

General registration for all members and guests will be conducted at the registration headquarters which will be located on the Mezzanine Floor of the Neil House on which the commercial exhibits will be located and on which all sessions of the Annual Meeting will be held with the exception of the two sessions of the Section on Obstetrics and Pediatrics which will be held in the Green Room (Main Dining Room) on the Lobby Floor.

Admission to all Sections and general sessions and to the special entertainments in connection with the meeting will be by badge only. Everyone in attendance must register to obtain a badge and therefore gain admission to the various sessions of the meeting.

Chapter 1, Sections 1, 2 and 3 of the By-Laws restricts registration and attendance at the Annual Meeting and its various sessions to members of the State Association in good standing. Physicians from outside Ohio who are members of their respective state medical associations, medical students and eminent members of scientific professions not medical but allied thereto, may be admitted as guests at the Annual Meeting.

Be sure to have your 1934 State Association membership card with you as its presentation at the Registration Headquarters will greatly facilitate the registering of members.

Annual Dinner

Friday Evening, October 5

Neil House

An informal dinner for all members who desire to attend will be held Friday evening, October 5, at the Neil House, sponsored by the Columbus Academy of Medicine.

The principal speaker following the dinner will be Professor Gus W. Dyer, professor of economics, Vanderbilt University, who has an enviable reputation as a student of social, economic and governmental questions and as an after-dinner speaker.

Sale of tickets for the dinner will be conducted by the Entertainment Committee of the Columbus Academy.

Scientific Exhibit

Blue and Pine Rooms

Neil House

Mezzanine Floor—End of West Corridor

An attractive and interesting lay-out of scientific exhibits has been arranged by the Committee on Scientific Exhibits of the Columbus Academy of Medicine.

The Scientific Exhibit will be located in the Blue and Pine Rooms at the end of the west corridor, Mezzanine Floor, Neil House, and will be open to members at all times during the two and one-half days of the Annual Meeting.

The scientific exhibits have proved one of the outstanding features of the past two annual meetings.

Organization Luncheon

Friday, October 5

Neil House

The annual Organization Luncheon for the presidents, secretaries, treasurers, legislative and medical defense committeemen and members of the House of Delegates of the component county societies and academies of medicine and the state officers, councilors, members of the State Association committees and section officers will be held Friday noon, October 5, at the Neil House.

The luncheon will begin promptly at 12 o'clock in order that it and the program to follow can

THE HEART OF COLUMBUS, SCENE OF 88th ANNUAL MEETING OF THE STATE ASSOCIATION



THE above picture, snapped from the dome of the State Capitol, shows the heart of Columbus which will be the scene of the Eighty-Eighth Annual Meeting of the Ohio State Medical Association in Columbus, Thursday, Friday and Saturday, October 4, 5 and 6. In the left foreground is the Neil House, the headquarters hotel and place where all the activities of the Annual Meeting will be staged. The monumental A.I.U. tower, located in the heart of the rapidly-growing Columbus Civic Center which already includes the Public Auditorium, State Office Building, Municipal Building, Central Police Headquarters and new Federal Building, is shown in the background.

be completed in time to permit all in attendance to attend the Sixth General Session starting at 2:15 p. m.

Admission to the luncheon will be by special card only, which cards will be mailed to those expected to attend.

A program centering on legislative and governmental questions confronting organized medicine is being arranged for the luncheon session. Because of the vital importance of these problems, the officers and legislative committeemen in particular of all the county medical societies and academies of medicine should plan to be present.

Hospital Clinics

Wednesday, October 3

On Wednesday, October 3, the day preceding the opening session of the Annual Meeting, medical and surgical clinics will be held in various Columbus hospitals.

The schedule of clinics to be conducted by Columbus physicians is now being prepared by the Clinics Committee of the Columbus Academy of Medicine. A program of the clinics will be published in the October issue of *The Journal* and arrangements will be made to have copies of it available at various Columbus hotels.

HAVE YOU MADE HOTEL RESERVATIONS FOR COLUMBUS MEETING? IF NOT, DO SO NOW

Members of the State Association who have not already done so should make hotel reservations immediately for the 88th Annual Meeting of the State Association to be held Thursday, Friday and Saturday, October 4, 5 and 6 at Columbus.

An unusually large attendance is anticipated at this year's meeting to be held at the Neil House, which has been designated as the headquarters hotel, so it is especially important that hotel accommodations be obtained as early as possible.

Requests for reservations should be sent direct to the management of the hotel selected and verification of the reservation should be requested.

For the benefit of members who have not secured reservations, the list of Columbus hotels, their rates and conveniences, published in the August issue of *The Journal*, is being published again. It is as follows:

NEIL HOUSE

Headquarters Hotel

High Street Opposite State Capitol

655 rooms, all with bath; single room, $2.50 to $5.00; double room, $4.50 to $7.00; double room, twin beds, $5.00 to $7.00; suites, $7.00 up.

DESHLER-WALLICK

Broad and High Streets

1000 rooms, with bath; single room, $2.50 to $7.00; double room, $5.00 to $12.00; double room, twin beds, $6.00 to $12.00; suites, $10.00 to $25.00.

FORT HAYES

33 West Spring Street

300 rooms, with bath; single room, $2.00 to $3.00; double room, $3.50 to $5.00.

CHITTENDEN

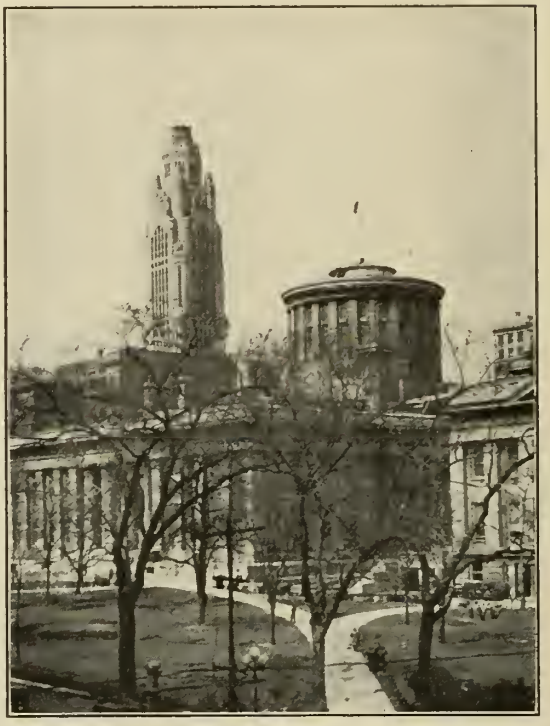
Spring and High Streets

275 rooms; single room, with bath, $1.75 to $3.00; single room, without bath, $1.50 to $1.75; double room, with bath, $3.00 to $4.00; double room, without bath, $2.25 to $3.00; double room, twin beds and bath, $4.50 to $5.00; double room, twin beds but without bath, $3.50.

SOUTHERN

Main and High Streets

230 rooms; single room, with bath, $2.00 to $3.00; single room, without bath, $1.50 to $2.00; charge of $1.00 for each extra person and $1.00 additional for rooms with twin beds.



THIS interesting and artistic photograph of the State Capitol, with the A.I.U. tower in the background, was taken by Dr. C. L. Cummer, Cleveland, president of the State Association, from a balcony of the present Columbus Federal Building, State and Third Streets, directly across the street from the Hartman Theater Building in which the new Headquarters Offices of the State Association are located.

NEW VIRGINIA

Third and Gay Streets

130 rooms; single room, with bath, $1.50 to $2.50; double room, with bath, $2.50 to $3.50; single room, without bath, $1.25 to $1.50; double room, without bath, $2.00 to $2.50.

COLUMBUS

Long and Fifth Streets

200 rooms; single room, with bath, $1.50; double room, with bath, $2.50; single room, without bath, $1.00; double room, without bath, $1.75.

JEFFERSON

17 East Spring Street

80 rooms; single room, with bath, $1.75 to $2.25; single room, without bath, $1.25 to $1.50; double room, with bath, $3.00 to $4.00; double room, without bath, $2.50 to $3.00; suites, $5.00.

GOLF TOURNAMENT, OCT. 3, AND OHIO STATE-INDIANA FOOTBALL GAME, OCT. 6, ADDED ATTRACTIONS FOR ANNUAL MEETING OF STATE ASSOCIATION IN COLUMBUS

TWO ATHLETIC events scheduled for the first week in October will offer first-class diversion for members of the State Association in attendance at the 88th Annual Meeting of the Association in Columbus, Thursday, Friday and Saturday, October 4, 5 and 6.

On Wednesday, October 3, the day preceding the opening of the Annual Meeting, the Fourteenth Annual Tournament of the Ohio State Medical Golfers' Association will be held at the Columbus Country Club.

On Saturday afternoon, October 6, the football teams of Ohio State University and Indiana University will meet at Ohio Stadium.

Sporty Columbus Course Will Be Scene of Golf Tournament

ALL that will be required to make the Fourteenth Annual Tournament of the Ohio State Medical Golfers' Association, scheduled for Wednesday, October 3, at the Columbus Country Club as a lid-lifting event for the 88th Annual Meeting of the Ohio State Medical Association to be held Thursday, Friday and Saturday, October 4, 5 and 6, the best tournament ever held by the golfers' association, will be a record-breaking attendance of physician golfers from all over the state.

The scene of the event is one of the sportiest and best kept layouts in Ohio. Its rolling fairways and lightning-fast greens will offer a rare treat for dubs as well as par-busters. Besides, the management of the club is notorious for arranging banquets of super-excellence and has promised to outdo itself in preparing for the golf banquet to be held following the tournament.

The second treat in store for the physician golfers is the alluring list of prizes which has been assembled by Dr. Carl Hyer, chairman of the local committee in charge of arrangements of the golf meet, and his committee consisting of Drs. Frank Watson, John Thomas, Robert Nosker and William Drake, supervised by Dr. F. C. Haney, president of the Ohio State Medical Golfers' Association. Prizes will be offered for low scores, high scores, fewest putts, most putts, most pars, most birdies, longest drives, etc.

In addition, the regular official trophies will be awarded, the list of which has been augmented this year by a rotating cup presented by the *Ohio State Medical Journal* and known as the Ohio State Medical Journal Junior Golf Trophy. The other cups to be played for are: Ohio State Medical Golfers' Association Championship Cup awarded for low gross score for 36 holes; President's Trophy awarded for low net score for 18 holes, 18 handicap or under; Granddad's Cup awarded for low gross for 27 holes among players 50 years of age or over, and the John T. Murphy Team Trophy awarded to the five-man team from any city turning in low aggregate score.

As pointed out in the August issue of *The Journal*, every male member of the Ohio State Medical Association is eligible to membership in the golfers' association and to participate in the tournament on payment of an enrollment fee of $2.00 which makes him a life member. Those wishing to become members may send their check for $2.00 to Dr. J. B. Morgan, Medical Arts Building, Cleveland, secretary of the golfers' association, or pay when teeing off the day of the tournament. Nominal greens fees have been arranged for all competing players.

The Columbus Country Club is located about six miles east of Columbus on East Broad Street.

Football Game Tickets Should Be Ordered Direct from University

PHYSICIANS attending the Annual Meeting who can arrange to stay over for the Ohio State-Indiana football game scheduled for 2 p. m. on Saturday afternoon, October 6, undoubtedly will be afforded a real treat.

The game with Indiana will be the first real test for the Ohio State 1934 team under the guidance of Francis A. Schmidt, the new Buckeye coach. Incidentally, it will be the first major battle for the 1934 Indiana eleven under the direction of "Bo" McMillan, former Center College star and famous for his stellar performances



AT the request of Dr. F. C. Haney, Columbus, president of the Ohio State Medical Golfers' Association, the above cartoon by the famous cartoonist, Billy Ireland of the *Columbus Dispatch* is presented here.

against Harvard a few years ago. Schmidt and McMillan are both said to be believers in unorthodox methods and supporters of the theory that a good offense is necessary to win football games. Therefore, a game with frequent scoring and plenty of thrills is anticipated.

Since this game, because of its unusual features, will undoubtedly attract a much bigger crowd than usually attends an early-season contest, it is important that those desiring to attend order their tickets at once.

Orders for tickets should be sent direct to the Football Ticket Office, Ohio Stadium, Ohio State University, Columbus. The order should be accompanied by a check or money-order covering the total cost of the ticket or tickets desired, plus 5 cents postage to be used in mailing the tickets to the purchaser. The prices for the Ohio

State-Indiana game are $1.80 per ticket for a reserved seat and $2.50 for a box seat, which price includes the federal and state admissions taxes.

In ordering tickets, indication should be made as to preference of location. Ohio Stadium has two decks. Section A includes the first 32 rows of seats in the lower deck; Section B includes the remaining seats in the lower deck all of which are under cover; Section C includes all seats on the top deck. All seats whether in the lower or upper deck are the same price, $1.80.

All orders for tickets are handled by the Football Ticket Office routinely and in the order of reecipt, so those who send their orders in promptly will be assured better locations than those who wait until the last minute. Tickets will be mailed out by the ticket office so as to reach the purchaser about a week before the day of the game.

No orders for tickets will be handled through the Headquarters Office of the State Association since arrangements have been made with the University Football Ticket Office to have immediate attention given orders sent in by physicians expecting to be in Columbus for the Annual Meeting.

— OSMJ —

Principles of Cooperation Suggested Between Medicine and Pharmacy

In a report made to the Ohio State Pharmaceutical Association at its recent annual meeting, Professor Edward Spease, dean of the College of Pharmacy, Western Reserve University, discussed the question of professional cooperation between physicians and pharmacists.

Professor Spease cited conferences which have been held by representatives of the Cleveland Academy of Pharmacy and presented the following summary of principles and concepts covering the relationship between physician and druggist which have been adopted by both academies:

Principles of cooperation—(1) The welfare of the public requires a close cooperation between an intelligent, well trained medical profession and a pharmaceutical profession equally intelligent and equally well trained in its special field; (2) personal contact between the physician and the pharmacist is essential in securing and maintaining this cooperation; (3) the relationship between these two groups is not stationary but will require a continuous modification and elaboration of concepts and principles with changing conditions.

Concepts—(1) The public is entitled to the best possible medical care; (2) such medical care postulates not alone competent doctors but accurate and ethical pharmaceutical service; (3) the natural corollary is that these two are mutually interdependent; (4) the mutual understanding of the Codes of Conduct of the two groups obviously will facilitate the service each can render to the other; (5) the establishment of an understanding acquaintance between the pharmacist and the physician who practices in his district is essential for intelligent cooperation; (6) the maintenance of this understanding once established depends upon the ability of the pharmacist to meet his obligation as a scientifically trained person; (7) this understanding acquaintance is based upon personal contact not only in the pharmacy but in the office of the physician as well; (8) under these circumstances the discussion of mutual problems is facilitated and the obligation of the pharmacist to make available to the doctor information of the progress of pharmacy can be best met; (9) the public is entitled to the best and most accurate professional pharmaceutical service at the lowest cost consistent with a reasonable profit to the pharmacist for this service; (10) such a service cannot be furnished to the public through the use of proprietary medicines of known or unknown formulae since they are not designed for this purpose; (11) the use of proprietaries by doctors either by prescriptions, sample or word of mouth, tends to favor self-medication with its attendant dangers to the patient; (12) it is the obligation of the medical men to be familiar with the action of drugs and prescription writing so that he will not have to take advantage of formulae suggested by proprietary medicine manufacturers or by their detail men; (13) the pharmacist by virtue of the accuracy of his information should supplant the detail men; (14) the discussion of details of the mechanics of pharmacy will naturally follow the establishment of this cooperation between physician and pharmacist; by mechanics we mean counter-prescribing, office dispensing, methods of handling prescribed proprietaries, cost of extra services aside from some of the materials and true pharmaceutical service and similar details affecting the working relationship between physician and pharmacist.

— OSMJ —

Plan Memorial for Dr. Shipley

A committee of civic leaders of Canton is soliciting funds to be used to equip an emergency unit at the Aultman Hospital, that city, as a memorial to the late Dr. Ralph T. Shipley, for many years chief of staff of the hospital. The committee hopes to receive all contributions by October 1. The funds are being received by George H. Deuble, care the Peoples Commercial and Savings Bank, Canton. Mr. Deuble is chairman of the committee, the other members of which are: Dr. J. B. Dougherty, Dr. Charles A. LaMont, W. J. Evans, Howard Fawcett, John Fawcett, H. W. Hoover, G. A. Leonard, Jesse H. Mason, J. P. Moseley and H. E. Patrick.

The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

Representative Government in Organized Medicine

The theory of self-government has always been close to the hearts of the American people. In accordance with the national ideal, our own Association has made ample provision for democratic control. The House of Delegates is the governing body of this Association, the Council being elected by it, and merely carrying on its functions between the annual sessions. The membership of the House of Delegates is truly representative of the county societies, for any county, no matter how small its membership, is entitled to at least one representative, while counties with membership exceeding one hundred are allowed one delegate for each one hundred members or fraction thereof. Therefore at our last meeting in Akron, counties with but a handful of members were entitled to one delegate and counties with over ninety members but less than one hundred members likewise had one delegate, and no more.

For many years the actions of the House of Delegates have guided the Council and officers by means of resolutions which have been adopted from time to time and which in the aggregate compose the policies of this Association. There is scarcely a topic of importance with economic or social bearing upon the practice of medicine which has not been considered in this way and there is ample record of the convictions of the House of Delegates. These policies have not been formulated by any one man or by a group of men, but by the action of this representative body. Such a form of government is as democratic as can be devised and still be efficient, but unfortunately it has the inherent weakness of democratic government in depending upon the continued interest of its constituency to express itself through the means provided. The attendance in our House of Delegates leaves much to be desired, for year after year certain counties are not represented at all, and many delegates attend only one of the two sessions. My purpose in writing this communication is to arouse your interest in your own legislative body.

In these troublous times which have made the majority of us exceedingly critical of all things, there may be those who feel that the correct solutions have not been reached or the proper actions taken. Errors in judgment are indeed possible, for there are few individuals or organizations which can establish a claim to absolute infallibility, but after all, the mistakes are those of honest men charged with the duty of carrying out representative government. And it might be cause for amusement to a cynic that much of the criticism for lack of leadership has come from the very counties which have been most delinquent in the matter of representation at the annual sessions of the House of Delegates.

For the county societies and for the State Association, the choice of delegates is a matter of vital importance. Only those should be chosen who are deeply interested and who are willing and able to attend the meeting. The selection of an alternate is of equal importance, since in case of emergency he should be readily available for intelligent service. Many counties are fortunate in having well-informed members serve year after year. Naturally they are of great value, because they understand the methods of procedure, and being experienced and personally known, are more likely to be chosen for important committee posts. Sound policy for a county society would be, to re-elect a delegate if he attends regularly and takes an active and intelligent interest, but if the roll-calls of previous meetings show absence or irregular attendance, then in the interests of the society and its membership, someone should be selected who will serve consistently and conscientiously.

A member accepting election as delegate obligates himself to make serious preparation for his duties. He should remember that the floor of the House of Delegates is the proper place for the expression of opinions on the vital social, legislative, and economic questions of the day. Delegates should prepare for their duties by familiarizing themselves with the actions of the Association throughout the year by reading the Council minutes, the annual committee reports which will be printed in the October issue of *The Journal*, and the informative articles which have appeared on public questions during the year in *The Journal*.

A few words about the organization of the House and its procedure may be helpful to delegates serving for the first time. At the opening sessions, committees are appointed. The majority are made on nomination of the president with the consent of the House, but the important Nominating Committee is appointed from the floor. One member is chosen from each of the ten councilor districts, and it is advisable for the representatives in a given district to caucus and, if possible, select a member suitable to the majority. There is nothing to prevent the nomination of additional names from the floor, and when such additional names are proposed for the committee, choice is by ballot vote. This year the

Nominating Committee will select a slate for the councilors from the odd-numbered districts, submitting this at the second session. Resolutions are introduced at the first session. Delegates should be informed of the fact that subjects can be brought up for discussion on the floor practically only by means of resolutions, which must be introduced at the first session and referred to the Resolutions Committee for its consideration, to be reported out for consideration at the second session.

At the second session, held on the following day, elections are held. Nominations for the office of president-elect are made from the floor, while those for councilors are made by the Nominating Committee selected on the previous day, although additional nominations may be made from the floor. A reference committee, appointed the preceding day, reports on the addresses of the president and the president-elect, neither of which can be published or released to the public press until approved by the House. Other reference committees review the reports of the various standing and special committees. In the consideration of any of these reports, enquiry and general discussion are in order. The Committee on Resolutions reports its recommendations on the resolutions introduced the preceding day. These resolutions are of the greatest importance, because they may establish policies of far-reaching importance.

The year just closing has been one of many vicissitudes. Social conditions and governmental actions have brought revolutionary changes and serious problems to organized medicine. To meet the situation and to prepare for the future, decisive actions have been taken by your Council, which hopes that the membership gives approval and stands unitedly behind it. However, the membership is given the opportunity to express its approval or disapproval through its representatives in the House of Delegates and to formulate policies for the coming year. Therefore, you who are members of the component county societies are urged to make certain that your delegates and alternates attend and participate actively in the important deliberations of your governing body.

"STUDY OUTLINE" ON TUBERCULOSIS THIRD OF SERIES BEING PUBLISHED IN JOURNAL

This month *The Journal* presents the third of a series of "study outlines" being published for the purpose of assisting the officers and program committees of the component county medical societies and academies of medicine in formulating programs for meetings that will tend to stimulate local interest and attendance and afford an opportunity for more members to participate in each program presented by the society.

The third "study outline", formulated by Dr. H. V. Paryzek, Cleveland, deals with the subject of "Pulmonary Tuberculosis".

The first two outlines of the series were published in the August, 1934, issue of *The Journal*, pages 522-526, together with explanatory comments on the idea by Dr. C. L. Cummer, the President, on his President's Page.

Study Outline No. 1 was prepared by Dr. J. F. Weitz, Montpelier, and dealt with the subject, "Scarlet Fever". Outline No. 2 handled the subject, "Peritonitis", and was prepared by Dr. Carl H. Lenhart, Cleveland.

Additional "study outlines" will be published in subsequent issues of *The Journal*.

Any program committees of the component county societies interested in participating in this innovation should refer to the August issue of *The Journal* for detailed information concerning the idea.

Study Outline, No. 3

Pulmonary Tuberculosis

By H. V. PARYZEK, M.D.
CLEVELAND, OHIO

OUTLINE FOR STUDY

1. Symptoms:
   a. Cough.
   b. Expectoration.
   c. Hemoptysis.
   d. Anorexia.
   e. Loss of weight.
   f. Fever.
   g. Night sweats.
   h. Pain.
2. Types:
   a. Incipient.
   b. Acute ulcerative.
   c. Chronic ulcerative.
   d. Chronic fibroid.
   e. Pleurisy with effusion.
3. Diagnosis:
   a. Physical signs in chest.
   b. Persistence of rales in upper chest.
   c. Importance of eliciting rales after coughing.
   d. Impaired motion of chest on involved

side.
e. Change of breath sounds.
f. Emaciation.
g. Anemia.
h. Fever.
i. Positive sputum.
j. Positive roentgen-ray findings.

4. Etiology:
a. Immediate.
b. Predisposing factors.

5. Transmission:
a. Human.
b. Bovine.

6. Complications:
a. Enteritis.
b. Laryngitis.
c. Pneumothorax.
d. Kidney involvement.
e. Empyema.
f. Ulceration of mouth and tongue.
g. Peritonitis.

7. Prophylaxis:
a. Isolation of open case.
b. Follow-up of contacts.
c. Disposition of sputum.
d. Routine sick room procedure.

8. Treatment: (Home or sanatorium)
a. Prolonged bed rest.
b. Ample diet.
c. Bathing and general hygiene.
d. Medicinal.
e. Local rest.
(1) Shot bags.
(2) Corsets.
(3) Body position.
f. Pneumothorax.
g. Removal or crushing of phrenic.
h. Pneumolysis.
i. Thoracoplasty.

PAPERS

1. General consideration of the disease.
2. Discussion of diagnosis.
3. Complications and their treatment.
4. Medical treatment.
5. Surgical treatment.
6. Discussion of public health problems.

— OSMJ —

In a recent opinion interpreting certain sections of the Ohio Minimum Wage Law, Attorney General John W. Bricker held that the law is applicable to the laundry departments of Ohio hospitals employing women or minors.

Wapakoneta—Dr. R. C. Hunter has been named departmental surgeon, Department of Ohio, United Spanish War Veterans.

Wilmington—A talk on "Preventive Medicine" was made by Dr. E. Dalton Peelle at a luncheon meeting of the local Rotary Club.

License To Practice in Ohio Granted To 42 Physicians Through Reciprocity

The following physicians have been licensed through reciprocity by the State Medical Board to practice medicine and surgery in Ohio:

Drs. Lloy D. Bonar, Mansfield, University of Cincinnati; James J. Carter, Cincinnati, Meharry Medical College; Mary C. Carter, Cincinnati, University of Louisville; William T. Cooke, Toledo, St. Louis University; Martin Decker, Middletown, George Washington School of Medicine; Milton T. Ebner, Lakewood, St. Louis University; Charles J. Farinacci, Cleveland, University of Maryland; Rodolfo F. Fasoli, Elyria, Medical College of Virginia; Robert R. Freund, Byesville, University of Chicago; Thomas S. Gerspacher, Cleveland, University of Louisville;

John R. Harding, Cincinnati, Louisiana State University Medical Center; Harry Hauser, Cleveland, University of Texas Medical School; Francis J. Heringhaus, Mansfield, University of Michigan; Joy D. Huss, Toledo, St. Louis University; James B. Johnson, Jr., Granville, Medical College of Virginia; Edward J. Keeney, Cuyahoga Falls, St. Louis University; Joseph B. Kupec, Youngstown, St. Louis University; Forest E. Lowry, Urbana, Jefferson Medical College; John A. Maczuga, Cleveland, St. Louis University; Floyd A. McCammon, Payne, Indiana University; Charles A. McReynolds, Poland, University of Colorado; John S. Myers, Versailles, St. Louis University; Edwin R. Murbach, Archbold, University of Michigan; George B. Nelson, Cleveland, George Washington University; Mixon L. Newsome, Warren, Meharry Medical College; Wilford D. Nusbaum, Columbus, Indiana University; George F. Peer, Bethesda, University of Maryland; John O. Robben, Cleveland, St. Louis University;

Edward C. Roy, Cleveland, St. Louis University; Albert M. Shrader, Waverly, University of Michigan; Robert L. Smead, Toledo, University of Louisville; Joseph R. Smith, Cleveland, Medical College of State of South Carolina; Carl A. Stas, Cleveland, St. Louis University; Rudolph A. Styble, Cleveland, St. Louis University; John H. Tildes, Cleveland, University of Michigan; Abram L. VanHorn, Columbus, University of Michigan; Louis A. Vogel, Lakewood, St. Louis University; Philip D. Weems, Portsmouth, University of Tennessee; Charles J. Wood, Genoa, St. Louis University; Gerald G. Wood, Rossford, University of Michigan; Earl B. Zurbrugg, Cleveland, Washington University, and Samuel S. Danzinger, Columbus, Detroit College of Medicine and Surgery.

— OSMJ —

Portsmouth—Dr. W. J. Hartlage a recent graduate of the University of Cincinnati College of Medicine has opened offices at Sciotoville.

RECENT DEVELOPMENTS AND PRESENT STATUS IN THE MEDICAL RELIEF SITUATION

Recent reports from a number of Ohio counties indicate that the problem of adequate financing of medical service in connection with the state relief program continues to be acute in some parts of, if not the entire, state.

Although expenditures in the state as a whole for medical services to the needy have increased slightly each month during the past six months (August, 1934, issue *The Journal*, page 528), the total amount allotted by the State Relief Commission each month continues to be inadequate to meet the needs of the state as a whole, causing an acute situation in a considerable number of counties.

As pointed out on previous occasions, this unsatisfactory situation is due to two things:

First, the arbitrary ruling of the State Relief Commission that total funds spent by a county each month for medical care shall not exceed an amount equal to $1 per family on the relief rolls of the county for that month.

Second, failure on the part of some county relief directors to budget even the available funds for medical services, and their failure to realize the importance of the medical phases of the relief program, resulting in the use of money available for medical services for other types of relief.

Despite repeated and emphatic demands on the part of officers and committees of the State Medical Association and representatives of many county medical societies for elimination of the $1-per-family-per-month limitation on expenditures for medical services, the State Relief Commission has refused to rescind this provision. The Commission has ignored all arguments pointing out the injustice of arbitrarily fixing an inflexible maximum limit on money which can be used for medical services and the fact that there is nothing in the rules and regulations of the Federal Emergency Relief Administration governing the use of federal funds which even implies that a limitation of this kind be placed on the use of money for necessary medical care.

Naturally, as long as this provision in the rules and regulations governing medical service to the poor in Ohio is in effect, adequate funds for medical services will not be available throughout the state as a whole and some counties will be compelled to resort to drastic pro-rating in the payment of medical bills.

The other chief cause for the lack of money for medical services is a problem which can be solved only by concerted local action on the part of physicians, dentists and nurses.

Some county relief directors have disregarded the importance of adequate medical care for those on the relief rolls. They have failed to place in their monthly budgets a request for funds for medical services even equal to the $1-per-family maximum allowance. In some instances they have frankly admitted that their reason for requesting meager amounts for medical services was because this would make more money available for other relief activities. Moreover, some county directors have refused to confer or discuss with representatives of their local medical society medical questions or make any effort to establish mutual cooperation in administration of the medical relief program.

NECESSITY FOR BUDGET REQUEST

Where such a situation exists, the county medical society should exert every effort to convince the county relief director of the need for more funds for medical services and request that he include in his monthly budget an amount equal to the maximum allowance if necessary. He should be shown the injustice of slashing bills for necessary medical services or refusing to authorize necessary medical care in order to increase funds for other types of relief. Offers of cooperation and assistance should be made and an effort put forth to develop a sympathetic understanding between the director and the medical profession.

Gradual increases in the amounts of money available in Ohio for relief activities of all kind during the past few months indicate that in most counties more funds for medical services would be available if proper consideration is given by all county relief directors to the medical phases of relief.

Ohio's relief budget for the month of August was $8,425,924, with 176,224 families on the relief rolls. This exceeded the July budget by $1,560,924 and the June budget by $2,263,148. Of the total outlay for August, $6,872,990 was from federal funds, $1,454,050 from state funds, and $98,884 from local funds.

THE AUGUST ALLOTMENTS

The budgetary allotments for direct and work relief and the number of families on relief in the various counties for the month of August follow:

County	Direct Relief	Work Relief	No. Families on Relief
Adams	$ 7,573	$ 3,390	425
Allen	30,494	23,169	1229
Ashland	5,750	5,182	263
Ashtabula	27,145	15,802	1186
Athens	35,018	13,316	2112
Auglaize	5,151	5,539	575

Belmont	42,713	46,566	4925
Brown	2,818	.....	750
Butler	70,319	52,298	3200
Carroll	8,759	3,630	520
Champaign	6,408	4,761	425
Clark	37,406	40,531	2408
Clermont	6,805	5,299	520
Clinton	5,500	3,362	450
Columbiana	53,604	40,964	2531
Coshocton	5,777	4,618	424
Crawford	14,016	8,846	719
Cuyahoga	1,284,725	469,089	36,780
Darke	5,374	2,803	450
Defiance	6,865	4,714	400
Delaware	7,280	5,568	426
Erie	19,165	16,325	998
Fairfield	11,698	9,706	800
Fayette	5,170	6,962	400
Franklin	229,252	217,798	7250
Fulton	10,247	.....	515
Gallia	6,041	2,752	425
Geauga	4,810	2,890	250
Greene	5,636	21,327	614
Guernsey	19,212	10,118	1025
Hamilton	553,767	291,745	22,000
Hancock	8,415	7,908	700
Hardin	13,490	3,241	975
Harrison	1,844	.....	144
Henry	13,251	4,651	750
Highland	4,525	6,797	450
Hocking	15,934	10,674	1175
Holmes	5,155	.....	300
Huron	7,314	7,098	500
Jackson	18,666	6,241	1250
Jefferson	24,876	23,967	1450
Knox	8,603	4,300	500
Lake	7,357	14,176	518
Lawrence	21,811	14,864	1668
Licking	19,853	14,864	1450
Logan	8,885	5,814	475
Lorain	14,705	26,719	933
Lucas	392,434	241,209	14,505
Madison	8,342	5,180	650
Mahoning	201,477	111,222	8500
Marion	30,781	21,488	1384
Medina	6,749	2,753	441
Meigs	19,080	8,597	1150
Mercer	3,560	2,692	330
Miami	11,224	14,061	818
Monroe	2,360	2,993	354
Montgomery	196,211	108,909	7100
Morgan	2,493	3,253	200
Morrow	3,458	2,752	185
Muskingum	42,926	27,616	2312
Noble	1,285	5,482	110
Ottawa	6,596	26,744	300
Paulding	7,092	.....	425
Perry	11,910	10,570	600
Pickaway	5,285	5,749	972
Pike	7,723	.....	550
Portage	25,028	12,619	980
Preble	4,660	2,590	400
Putnam	7,779	3,167	400
Richland	16,505	18,434	760
Ross	24,110	5,179	1350
Sandusky	11,363	8,171	645
Scioto	36,000	24,310	1858
Seneca	15,825	11,992	700
Shelby	8,582	6,308	450
Stark	89,438	97,029	3750
Summit	202,758	156,931	7231
Trumbull	83,586	28,789	3800
Tuscarawas	29,771	28,913	1550
Union	8,610	4,146	450
Van Wert	8,540	5,781	450
Vinton	6,083	3,523	382
Warren	10,679	4,692	668
Washington	16,886	10,977	1250
Wayne	5,940	5,542	490
Williams	8,068	3,204	625
Wood	24,762	28,209	1200
Wyandot	5,704	2,590	425

The figures on the number of families on relief in each county show how much money should have been available in each county for medical services during the month since each county is entitled to $1 for each relief family. Of course unless the county relief director had requested such an amount in his budget, the full maximum allowance undoubtedly was not available. The foregoing figures show that in many counties even with the maximum allowance based on the number of families on relief, funds for medical services are inadequate, while in others the maximum allowance is sufficient to take care of medical bills during periods of low sickness incidence.

ANOTHER TYPE OF RELIEF PLANNED

In making up the budget for August, the State Relief Commission allotted $110,000 to be distributed to 68 counties for work projects for needy and unemployed professional and "white collar" workers.

Just what type of projects will be set up for this class of unemployed is quite vague. The statement by the Relief Commission in announcing this new feature stated "the projects will include planning, public welfare, public health, recreation, arts, research, general clerical work, etc."

It was stated that workers employed on these professional and clerical projects will include: attorneys, abstractors, accountants, actors, agents, architects, artists, assayers, authors, bookkeepers, cashiers, chemists, clerks, collectors, credit men, decorators, dentists, designers, draftsmen, editors, engineers, gaugers, inspectors, inventors, laboratory assistants, librarians, metallurgists, musicians, office assistants, osteopaths, photographers, physicians, professional apprentices, reporters, research workers, salesmen, samplers, scalers, sculptors, showmen, statisticians, surgeons, stenographers, surveyors, teachers, art teachers, music teachers, technicians, telephone operators, trained nurses, typists and veterinary surgeons.

Selection of workers will be on the basis of need, the statement declared, but nothing was said regarding the kind of work they will be expected to do. Salaries will be determined on the usual work week, with a maximum daily pay of $2.50 and the hours to be those "traditionally expected of workers in their respective fields", but in no case will they be employed longer than seven hours in any one day nor more than five

days each week, the Commission's bulletin declared.

RATES FOR HOSPITAL CARE OF F.E.R.A. INJURED

The State Relief Commission recently announced rates, terms and conditions governing the hospitalization of those injured while employed on F.E.R.A. work projects following conferences with officials of the Ohio Hospital Association. All hospitals accepting persons injured on work projects will be expected to submit their bills in accord with the rates scheduled and to observe the rules and regulations promulgated in the agreement.

A per diem rate of $3.50 will be paid for "basic hospital in-patient service to include the cost of board, room, ordinary nursing service, services of resident staff when assisting the attending physician, medications and dressings."

For such hospital service as may be required in addition to the above, the following fee schedules are announced by the Commission:

A. Operating Room Fee Schedule—Major operation, $10.00; minor operation, $5.00; plaster casts: arm or leg, $3.00; body cast, $5.00; body cast one leg, $7.50; body cast two legs, $10.00; plaster splint, $2.00; anesthetic when administered by an employe of the hospital, $5.00.

B. Emergency Room Fee Schedule—Removal of body from cornea, $2.00; simple dressing, $2.00; antitetanus serum, $3.00; approximation of wounds with clips or sutures, reduction of fracture without anesthetic, and similar services, $3.00; extensive burns and procedures requiring an anesthetic, $5.00.

C. *X*-ray Fee Schedule—(less 20%—A fee of $10.00 will be allowed for *X*-ray of all parts of the body except fingers and toes, for which parts a fee of $5.00 will be allowed. These fees must not be exceeded except under the following conditions:

(1) An additional charge of $5.00 will be allowed for an examination for each additional part of the body when necessary, up to and including a maximum of $25.00 at one sitting.

(2) A fee of $5.00 will be allowed for subsequent examinations if such are necessary.

(3) An additional fee of $5.00 will be allowed for the accurate localization of a foreign body in the eye.

(4) $25.00 for complete *X*-ray examination of gastro-intestinal tract.

(5) $15.00 for complete *X*-ray examination of skull—not less than two views in different directions.

(6) $15.00 for pyelograms.

(7) 50% extra for stereoscopic negative when authorized.

Cervical, dorsal and lumbar regions of the spine are considered as separate parts in approving bills and both anterior-posterior and lateral views must be submitted. Entire pelvis and upper third of femurs is considered one part. Wrist and hand one part. Views in two directions of the same part (skull excluded) are considered as one examination of the part and are covered by one fee.

D. Laboratory Fee Schedule—(less 20%)—Urine analysis chemical, $2.00; urine analysis chemical and microscopic, $3.00; urine analysis special tests, $3.00; blood single count, $2.00; blood two counts, $3.00; blood complete count including differential, $5.00; blood typing for transfusion, $5.00; blood chemistry single tests, $3.00; bacteriological smears, $2.00; cultures, $5.00; spinal fluid, $3.00; tissues, $5.00; Wassermanns, $5.00.

E. Miscellaneous Fee Schedule—Physiotherapy per treatment, $1.50 less 20%; special nurses board per day, $1.00.

The regulations provide that hospitals shall be reimbursed for only such additional services enumerated under A. B. C. D. and E. as may be ordered by the attending physician.

Reimbursement will not be made for patients applying for after-care following discharge from a hospital or from the care of a physician. The regulations specify that an emergency case is any case which requires and applies for treatment within 24 hours after the accident and which has not had previous treatment by a physician.

The agreement states that "any claim for professional, scientific or ordinary service rendered an F.E.R.A. disability case which does not appear in the hospital accounts as a bona fide transaction between the hospital and the patient shall not appear in the hospital statement as a claim for compensation but that such claims shall be made in a separate statement by the party rendering the service, except in cases referred to a hospital solely for *X*-ray or laboratory service."

The rules and regulations, including the fee schedule, were made retroactive as of April 1, 1934.

—OSMJ—

Dinitrophenol Dangerous in "Reducing" Nostrums

The "reducing racket" has a group of new and dangerous drugs, dinitrophenol and related compounds, and racketeers are selling these drugs in fat reducers in spite of reports of deaths caused by their compounds, according to a statement by W. G. Campbell, Chief of the U. S. Food and Drug Administration.

"Reducing agents containing these drugs," says Mr. Campbell, "have sprung up like mushrooms all over the country, and are endangering the lives of patrons. The Federal Food and Drugs Act has no jurisdiction over products of this type, dangerous though they may be. All that the Food and Drug Administration can do is to warn the public that these compounds are dangerous."

ANNUAL ACTUARIAL REPORT OF WORKMEN'S COMPENSATION FUND INDICATES GRADUAL IMPROVEMENT IN LATEST STATUS

Condition of the State Workmen's Compensation Fund on December 31, 1933, was considerably better in comparison with the status of the fund for several preceding fiscal periods, indicating that the Workmen's Compensation system in Ohio has weathered the serious financial difficulties arising from the business depression and is progressing toward a comparatively normal state, according to the Annual Revision of Rules and Rates and Actuary's Statement issued August 1, 1934, by E. I. Evans, chief actuary of the State Industrial Commission.

The surplus of the State Workmen's Compensation Insurance Fund increased from $115,908.33 to $634,988.58, an increase of $519,080.25 during the calendar and fiscal year 1933 showing, according to Mr. Evans, "a favorable turn following two years of heavy drain upon the surplus".

The assets of the fund were reduced $1,751,277.71 during 1933, while the reserves for future payments of pending and incomplete claims and other obligations of the fund were reduced $2,270,357.96. This diminishing of liabilities at a more rapid rate than that of assets has served to increase the surplus of the fund, according to the actuarial report.

The following comparative tabulation of receipts and disbursements shows the situation which has confronted the Industrial Commission during the past five years:

Year	Receipts	Disbursements	Excess of Disbursements
1929	$16,221,264.67	$16,282,539.08	$ 61,274.41
1930	14,004,755.54	16,165,029.67	2,160,274.13
1931	11,544,899.14	16,077,209.54	4,532,310.40
1932	8,140,584.09	14,406,006.65	6,265,422.56
1933	8,820,381.47	12,896,361.28	4,075,979.81
Total	$58,731,884.91	$75,827,146.22	$17,095,261.31

It will be noted that receipts increased 8.4 per cent during 1933 in contrast with a sharp decline in receipts annually since 1929. Disbursements declined 10.5 per cent during 1933, maintaining a similar ratio of decline to that of 1932.

Analyzing the figures on receipts and disbursements, Mr. Evans states in his report:

"Due to disbursements being required to be made on claims over a long period of years, current conditions do not quickly affect disbursements. This comparison shows that the demand upon the reserves of the fund reached its peak in 1932 when disbursements exceeded receipts by $6,265,422.56, while in 1933 the excess disbursements was reduced to $4,075,979.81. The total of excess disbursements for the five years ending 1933 disclosed that $17,095,261.31 of disbursements were made from invested reserves and surplus during the depression, of which $11,870,333.45 was from claim reserves and $5,224,927.86 from the surplus fund.

"While the receipts and disbursements indicate a very favorable trend during 1933, which favorable trend is continued during the first half of 1934, there is still a large drain upon the fund to meet re-opened and continuing claims on accidents occurring in earlier years, many of which claims had become dormant prior to 1929 and were subsequently re-opened. Approximately $10,400,000 of the total disbursements of $12,896,361.28 for the year 1933 was on claims for accidents occurring prior to the year 1933.

"It is noted the receipts of 1933 are at a level of 45.6 per cent below the receipts of 1929, while disbursements of 1933 are at a level of only 20.8 per cent below the disbursements of 1929."

FIGURES SHOW BUSINESS CONDITIONS

The actuarial report presents an interesting comparative picture of business conditions during the period 1929 to 1933, inclusive.

The figures on the aggregate payroll of insured employers, the amount of premium paid, and the number of disability claims filed for that period are:

Year	Payroll	Premium	Claims Filed
1929	$1,578,886,096	$13,274,966	234,314
1930	1,383,802,716	11,128,799	193,005
1931	1,118,587,184	8,958,868	154,232
1932	838,775,495	5,990,994	117,866
1933	787,633,213	6,909,666	117,002

This tabulation shows that the payroll of insured employers for 1933 decreased 6.1 per cent below 1932 and was at a level of 50.1 per cent below 1929. Premium receipts, however, increased 15.3 per cent in 1933 over 1932 and were at a level of 47.9 per cent below 1929. Claims filed decreased .7 per cent in 1933 below 1932 and were at a level of 50.1 per cent below 1929.

"The increase in premium is attributable only in part to the increase in rates in past years", Mr. Evans points out.

"A portion of the premium increase is due to some of the more hazardous industries that have a high premium rate showing an increase in payroll during 1933 as compared to light hazard industries which have a relatively low rate having shown a decline in payroll during 1933.

"Another factor contributing to the increased premium receipts is the additional premium the fund has been able to collect after investigation had disclosed the proper returns had not been

made by some employers in past years. The fund has benefited by not only the additional premium collected from some of these employers whose payroll records have been investigated but also has benefited considerably by the influence such investigations have had upon other employers."

MEDICAL AND COMPENSATION COSTS DECLINE

The reports analysis and comments on the average cost per claim will be of particular interest to the medical profession.

It is shown that the average compensation cost per claim decreased 4 per cent below 1928 and the average medical cost per claim, including physicians', hospitals' and nurses' fees, was 5 per cent below 1928.

Comparing the level of claim cost in 1933 with 1932, the report shows that the average compensation cost declined 17 per cent while the average medical cost declined 36 per cent. A major portion of the decrease in medical cost was the result of the 20 per cent flat reduction in all physicians' fees ordered by the Commission and put into effect in the Spring of 1933.

Commenting on the claim cost figures, Mr. Evans said:

"It must be remembered that claim cost was at its peak in 1932 when claimants, doctors and hospitals filed many claims covering obligations that were withheld by them in previous years of high industrial activity."

ADMINISTRATIVE CHANGES AND PROBLEMS

The report makes a rather extensive review of some of the administrative changes which have confronted the Industrial Commission. That portion of the report is in part as follows:

"Effective May 15, 1934, the administration of the Workmen's Compensation Law, including the personnel associated therewith, was placed wholly under the Industrial Commission. This action was the result of a recommendation of the committee appointed by the Governor to investigate all matters pertaining to the operation of the Workmen's Compensation Law.

"While the function of the fund is that of providing benefits to workmen disabled through industrial accident or disease incurred in the course of employment, there has developed during the period of depression when great need for general relief is widespread, many appeals from those in distress as the result of disabilities which are not compensable from the fund. If general relief appeals are granted it will undermine the security of the benefits due the disabled and dependents of those killed in industry. The demands upon the fund in recent years have greatly increased the investigations and inquiries that justice may be done to those having meritorious claims and at the same time prevent the allowance of claims without merit. Frequently claims made are supported by employers, physicians and public agencies when upon investigation it is found that the only basis for the request is to relieve financial distress without regard to the relation of the claim to the claimant's employment.

"There has been an increasing tendency by many employers to not file necessary payroll reports on time and pay appropriate premiums, when due, all of which has required extended correspondence, investigations, audits, and in some instances court proceedings. Such conditions tend to increase the basic rates of the fund and place upon the responsive employers an undue burden of meeting the shortage of premiums occasioned by delay or by failure of unresponsive employers to pay appropriate premiums.

"The personnel and other facilities for the administration of the law have been greatly curtailed in recent years due to the reduction in appropriation by the Legislature. It is unfortunate that the general public is prone to assume, when industrial activities are being greatly curtailed, the work of the Industrial Commission would also be reduced. The true situation is that when industrial depression occurs the demands upon the fund become greater and more complex, requiring additional personal effort and increased facilities to meet the demands.

"In recent years the total funds appropriated for the administration of the Ohio law has equalled but one-sixth of the expense required by stock insurance companies for the administration of their workmen's compensation departments. In other states where private insurance companies carry workmen's compensation insurance employers must pay the expense of administration in their premium rates while the expense of operation of the Ohio fund is provided from taxation. If the department was adequately manned so that the fund would receive all of the premium properly due the basic premium rates could be reduced and prompter service rendered to employers, injured workers and their dependents."

One section of the report is devoted to a discussion of court appeals. It is pointed out that at the close of 1933 there was a 21 per cent increase in the number of cases appealed or in process of being appealed, these cases having been disallowed or compensation terminated by the Commission. This increase, the report states, necessitated the setting up of an additional reserve of $391,000 over and above the amount of reserve set up in 1932, making the total amount of reserve for such cases, $2,245,000. A considerable number of those cases had remained dormant for a number of years but were revived regardless of their merit by claimants and others in the hope of acquiring some material benefit.

NO INCREASE IN BASIC PREMIUM RATE

The revision of rates assessed employers effective July 1, 1934, and carried in the report,

maintains the same general level as in 1933. The revision carries no change in the basic rates on 295 classifications of industries and businesses. Increases are made in 139 classifications and decreased in 125. The occupational disease rate of 1 cent per $100 of payroll remains the same.

With reference to rates, the report declares:

"While the fund shows a favorable trend the surplus of the fund has not been replenished to a point that would warrant a general decrease in the rate level. At this point it is worthy of note that workmen's compensation rate levels in other states are still being increased.

"It was found necessary to increase the rates of some industries due to the unfavorable trend of the accident cost experience of those industries, while on the other hand rates have been reduced where the experience of the industry shows a favorable trend. The construction classifications with only a few exceptions continue to show an adverse trend, therefore, requiring a sharp rate advance in many instances. Utilities and manufacturing industries generally show a favorable trend, thus a large number of those classifications carry reduced basic rates."

The basic premium rate charged against all employers during the year July 1, 1933, to June 30, 1934, was approximately 28.8 per cent higher than the basic rate of the preceding year. Increases totaling 60.8 per cent were made in the basic rate during the years 1930-31, 1931-32, 1932-33 and 1933-34. (September, 1933, issue *The Journal*, page 591).

The report carried the following financial statement showing the condition of the compensation fund as of December 31, 1933:

ASSETS	Assets	Liabilities
Invested in bonds	$34,640,965.07	
Bank deposits (inactive)	41,322.70	
Bank deposits (active)	758,767.09	
Premiums in course of collection	2,025,149.17	
Accrued interest due fund	1,122,118.74	
Bond premium after amortization	505,025.77	
LIABILITIES		
Reserve held to cover awards on which payment is required to be made over a period of years, or during the life of the injured worker		$35,408,913.08
Reserve to cover warrants issued but not cashed		475,535.45
Reserve for portion of advance premium payments not already earned		2,018,163.14
Due Public Employe Fund		555,748.29
Net Surplus, statutory and general		634,988.58
	$39,093,348.54	$39,093,348.54

— OSMJ —

Must Have O.K. of Health Department

County Commissioners have no authority to provide for the care and treatment of tubercular persons in any place or institution which is not approved by the State Department of Health, according to a recent opinion rendered the health department by Attorney General John W. Bricker.

The Attorney General pointed out that a county may under proper circumstances afford relief to a person permanently disabled through tuberculosis in the individual's own home and may pay for the care and support of a tubercular child in an approved private family pending commitment to an institution for tubercular patients.

However, he declared that neither of the above provisions is a real exception to the statutory requirement that the places or institutions where tubercular patients are housed and cared for should be approved by the State Department of Health as a protection to other residents of the county.

— OSMJ —

Dr Hertzler to Conduct Lecture Series Sponsored by Lima Academy

Dr. Arthur E. Hertzler, professor of surgery, University of Kansas School of Medicine, will present the 1934 Post Graduate Lectures sponsored annually by the Academy of Medicine of Lima and Allen County.

Dates of the lectures are October 8 to 12, inclusive.

They will be on the subjects: "Surgical Pathology"; Surgical diagnosis", and "After-Care of Surgical Cases".

Ten lectures will be given by Dr. Hertzler from 4:30 to 5:30 p. m. and 6:30 to 7:30 p. m. daily.

Any member of the State Association is cordially invited by the Lima Academy to attend any or all of the lectures. Admission to single lectures will be $1.00. Those wishing to attend all ten lectures may take advantage of the special price of $7.50 for the entire series.

— OSMJ —

Seek To Bar Lay Agents From Industrial Commission Cases

A petition in prohibition has been filed by the Unauthorized Practice of Law Committee of the Ohio State Bar Association in the Supreme Court of Ohio seeking to prohibit the State Industrial Commission from permitting persons not admitted to the practice of law to represent claimants before the Commission.

It is alleged in the petition that the State Industrial Commission is an administrative body with quasi-judicial powers which is undertaking to usurp judicial power vested in the Ohio Supreme Court by prescribing those who may or may not practice before the Commission. Moreover, it declares that admission to the bar is vested exclusively with the Supreme Court and no other court, tribunal or commission may admit or regulate admissions to the bar. The petition admits the right of claimants to appear in their own behalf before the Commission.

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1316 Mahoning Bank Bldg., Youngstown	44581
2157 Euclid Ave., Cleveland	Prospect 1951
199 Olney Ave., Marion	Telephone 2118
2651 Gilbert Ave., Apt. No. 3, Cincinnati	Wodburn 7127
2352 Monroe Street, Toledo	Main 7962
871 W. Riverview Ave., Dayton	Fulton 7211
435 E. Liberty St., Springfield	M. 191
Normandie Hotel, Columbus	ADams 1569
General Hospital, Portsmouth	559

The Ohio State Nurses' Association also operates an employment bureau where nurses may be secured for physicians' and dentists' offices, hospitals, public health nursing organizations, official health organizations, etc.

OHIO STATE NURSES' ASSOCIATION, 50 East Broad Street, Columbus, Ohio

Deaths in Ohio

Matthias Borts, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1881; aged 82; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 22. Dr. Borts retired from active practice 20 years ago. Surviving are two sisters and two brothers.

Burton B. Buck, M.D., Waterville; Eclectic Medical College, Cincinnati, 1899; aged 72; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 3. Dr. Buck was a native of Milton Center but had practiced for many years in Lucas County. He was president of the Waterville Chamber of Commerce, the Rotary Club and Masonic and Odd Fellows lodges. Surviving are his widow and two daughters.

Samuel P. Deem, M.D., Rutland; Baltimore Medical College, 1883; aged 71; member of the Ohio State Medical Association and the American Medical Association; died July 5 of angina pectoris. He was one of the oldest physicians in Meigs County. Surviving are two step-children and two sisters.

Charles O. Hain, M.D., Western Reserve University School of Medicine, 1897; aged 64; died July 13 of heart disease. He was a member of the staff at Lutheran Hospital and had practiced in Cleveland for 35 years. Surviving are his widow and two sons, Dr. Oliver Hain and Dr. Dudley Hain.

James M. Hensley, M.D., Bellaire; licensed in 1896; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died July 26 at the Masonic Home, Springfield. Dr. Hensley was a native of Meigs County. Surviving are his widow, three daughters, two sons and one brother, Dr. George Hensley, Pomeroy.

William O. Kemper, M.D., Reading; University of Cincinnati College of Medicine; aged 26; member of the Ohio State Medical Association and the American Medical Association; died July 30. Surviving are his parents and one brother.

Cyrus Kirkley, M.D., Los Angeles; Starling Medical College, Columbus, 1868; aged 89; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 27 at Los Angeles, California. Dr. Kirkley was a pineer physician of Toledo and practiced there until a number of years ago when he moved to Los Angeles. He established the first private hospital in Toledo. He was a Fellow of the American College of Surgeons and the American Gynecological Society. Surviving are one son and two daughters.

Max Henry Klaus, M.D., Cleveland; Western Reserve University School of Medicine, 1902; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died July 15. He had practiced in Cleveland more than 20 years. Surviving are his widow, two sons, one sister and three brothers.

Isaac T. McCarty, M.D., Delaware; Western Reserve University School of Medicine, 1897;

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aged 66; former member of the Ohio State Medical Association and the American Medical Association; died July 11. Dr. McCarty had practiced in Delaware since 1918. He was a member of the Masonic and Elks lodges. His widow, one step-son, two brothers and two sisters survive.

William I. McCowan, M.D., Navarre; Medico-Chirurgical College, Philadelphia, 1909; aged 53; former member of the Ohio State Medical Association and the American Medical Association; died July 22 of carcinoma. His widow and one son survive.

Augustus Ravogli, M.D., Cincinnati; Royal University of Rome Faculty of Medicine and Surgery, 1873; aged 83; former member of the Ohio State Medical Association and a former Fellow of the American Medical Association; died July 25. Dr. Ravolgi had not been in active practice for a number of years. Before his retirement he was one of the most widely known dermatologists in the country. Dr. Ravogli served as president-emeritus of the Ohio State Medical Association in 1921-22 and was a former president of the Cincinnati Academy of Medicine, being an honorary member of the Academy. Dr. Ravogli was professor emeritus of dermatology and syphilology, University of Cincinnati, College of Medicine, where he taught for many years, and for many years was an active member of the American Dermatology Association, American Urological Association and the American College of Surgeons. He was affiliated with the Masonic and Pythian lodges.

William H. Riley, M.D., Vandalia; Long Island College of Medicine, 1885; aged 76; member of the Ohio State Medical Association and the American Medical Association; died July 27; Dr. Riley had practiced in Vandalia for more than 40 years. He retired from active practice two years ago but retained his active interest in professional, civic and business affairs of the community. He was affiliated with the United Brethren Church and the Odd Fellows Lodge. Surviving are his widow, one sister and four brothers.

George C. Schaeffer, M.D., Columbus; Miami Medical College, Cincinnati, 1896; aged 64; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died August 12 at Laporte, Indiana, following an extended illness. Dr. Schaeffer served with the British and American armies during the World War, holding the rank of lieutenant colonel, and established a reputation as one of the leading plastic surgeons of the world. While in active practice in Columbus, Dr. Schaeffer was a member of the staffs of Grant, Mt. Carmel, White Cross and Children's hospitals. He was a Fellow of the American College of Surgeons, Columbus Club, American Legion, Sons of

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the American Revolution and the Scioto Country Club. His widow survives.

Ralph T. Shipley, M.D., Canton; Western Reserve University, School of Medicine, 1910; aged 51; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 7 of acute leukemia. Dr. Shipley, a native of Guernsey County, practiced at Carrollton until 1917 when he served overseas with the rank of major. In 1920 he moved to Canton to become surgeon for the Republic Steel Corporation. Dr. Shipley was a member of the staff at Aultman Hospital and physician for McKinley High School athletic teams. He was a Fellow of the American College of Surgeons and a member of the Canton Medical Library Association. Surviving are his widow, two sons, and two sisters.

Judson A. Van der Hulse, M.D., Akron; Ohio Medical University, Columbus, 1899; aged 60; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 13. Dr. Van der Hulse was a native of West Mecca. He served as secretary of the Summit County Medical Society in 1905.

Stuart M. Watson, M.D., Newark; University of Cincinnati College of Medicine, 1931; aged 37; member of the Ohio State Mdical Association and a Fellow of the American Medical Association; died July 14 of injuries received in an automobile accident. Dr. Watson was a member of the Episcopal Church, Masonic Lodge and Alpha Kappa Kappa fraternity. His widow and one brother survive.

Ivan I. Yoder, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1904; aged 59; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 12 of heart disease. Dr. Yoder, a member of the staff at Lutheran Hospital, was active in Y.M.C.A. work. He was affiliated with the Masonic Lodge and Methodist Episcopal Church. Surviving are his widow, three brothers and one sister.

— OSMJ —

One Hundred Year Book Now Ready for Distribution

The *Hundred Year Book* of the College of Medicine, Ohio State University, is now off the press, and will be ready for delivery during the meeting of the Ohio State Medical Association in Columbus, October 4, 5 and 6, 1934.

The first volume contains a complete history of the medical school from 1834 to 1934, including the report of the Hundredth Anniversary Celebration and the addresses.

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News Notes From County Societies and Academies

First District

Adams County Medical Society met in regular session August 15 at Peebles, with wives of the members as guests. The following paper was presented: "Some results of the Mechanical Treatment of Pulmonary Tuberculosis", Dr. Harry F. Rapp and Dr. Samuel Meltzer, Portsmouth; discussion, Dr. Ray Vaughen, Cedar Mills. The society had as its guests Dr. John A. Caldwell, Cincinnati, president-elect of the State Association, and Dr. Parke G. Smith, Cincinnati, councilor of the First District. A luncheon was served at the High School.—Bulletin.

Highland County Medical Society in session July 5 was addressed by Dr. Robert L. Crudgington, Cincinnati, on "Obstetrics".—News Clipping.

Clinton County Medical Society met July 3 at Wilmington. The following program was presented: "Vincent's Angina Infection of the Throat and Sodium Perborate Treatment", Dr. Robert Conard; "Carcinoma of the Breast", Dr. S. A. Crabtree; "Vincent's Angina; Arsphenamine Intravenously, Treatment", Dr. John Anderson; "Two Cases of Mixed Diphtheria and Scarlet Fever", Dr. W. K. Ruble; "Prostatic Retention with Subsequent Resection with Good Results", Dr. W. B. Yoakley; "Conflicting *X*-rays on Gall Stones", Dr. C. E. Kinzel; "Enlarged Thymus in Infant with *X*-ray Therapy", Dr. E. D. Peelle.—News Clipping.

Sixth District

Mahoning County Medical Society held its annual golf outing July 19 at the Southern Hills Country Club. Prizes were won by Drs. W. A. Welsh, Carl Gustafson, F. R. Cafaro, Morris Deitchman, Peter Boyle, P. R. McConnell, E. C. Goldcamp, A. M. Rosenblum and P. Kennedy.

The society has announced that a series of lectures on "Recent Advances in Applied Physiology" will be presented during September by Dr. Carl J. Wiggers, professor of physiology, Western Reserve University, at the Y.M.C.A. Auditorium under the auspices of the society. The dates of the lectures are September 4, 7, 11, 14, 18, 21, 25 and 28.

Dr. Harlow Brooks, New York City, will address the society in October, the date for which has not been set.—Bulletin.

Seventh District

Tuscarawas County Medical Society was entertained on August 9 at the home of Dr. Roy Hildebrand, Newcomerstown. A roundtable discussion on cases was held and a society hour enjoyed.—Bulletin.

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The cereal-starch of PABLUM is more quickly digested than that of long-cooked cereals

FOR many years it has been the custom to cook infants' cereals one, two, and even three hours to increase their digestibility. The microscope (and clinical tests*) now prove that this bothersome and expensive long cooking is unnecessary with Pablum. For, being pre-cooked at 10 pounds steam pressure and dried, it is so well cooked that it can be served simply by adding water or milk of any temperature. Photomicrographs and also digestibility studies *in vitro* give evidence of this thorough cooking.

Fifteen cereals (both cooked and uncooked) studied microscopically were revealed as containing many starch granules, most of them massed into dense clumps. *Such unruptured clumps were never observed in hundreds of examinations of Pablum.* The latter consists, rather, of porous flakes which, like sponges, drink up liquids. Hence Pablum can be entirely saturated by the digestive secretions. This is borne out by studies of Ross and Burrill who found that the starch of Pablum is more rapidly digested than that of ordinary cereals cooked 4 hours.

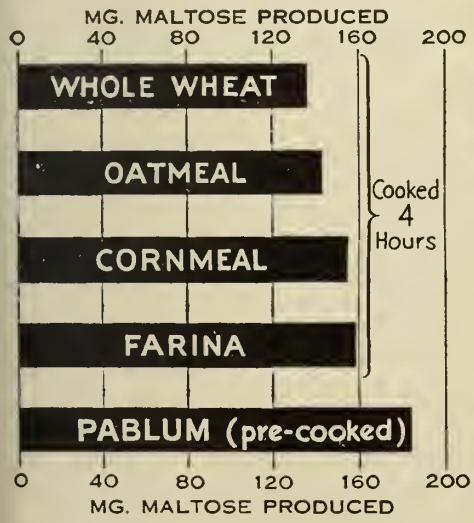
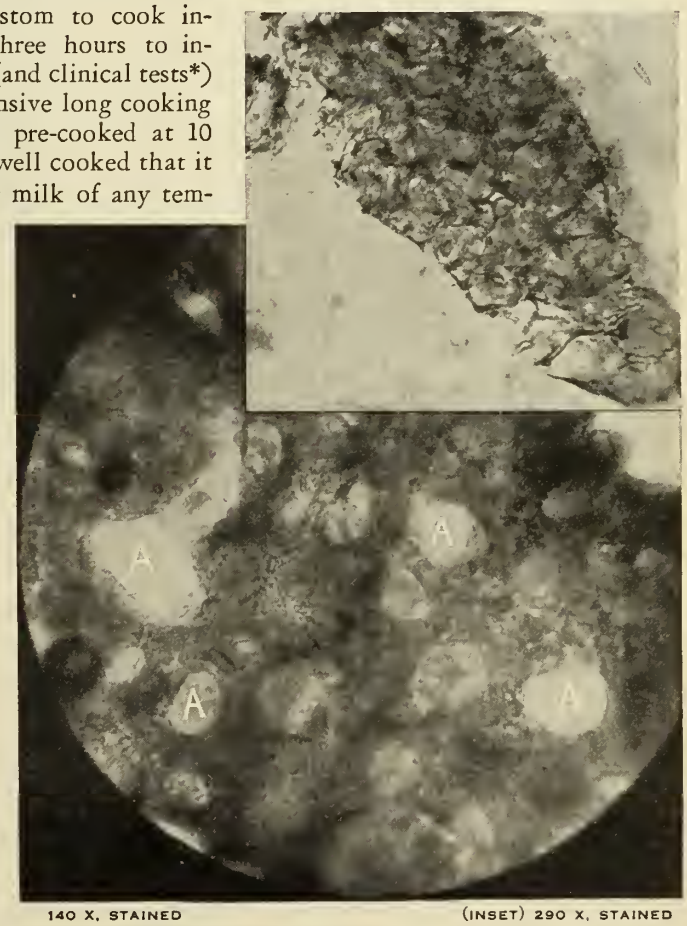


*Chart shows that maltose production is much greater for Pablum prepared with cold water than for other cereals cooked 4 hours. Ross and Burrill (Journal of Pediatrics, May 1934) conclude from this and from the total soluble carbohydrate formed that starch digestion of Pablum is more rapid than that of 6 other cereals.



140 X, STAINED (INSET) 290 X, STAINED

Large photomicrograph: Pablum mixed with cold water—portion of large flake. Pablum flakes are honeycombed with "pores" or air-spaces (note light areas A). This porosity permits ready absorption of digestive fluids by the entire flake. No starch granules are visible—they have been completely ruptured.

Inset: Farina cooked ½ hour—clump of cereal composed of unruptured starch granules. Note density of clump and lack of porosity. Many starch granules, such as are present in raw cereal, remain unchanged in form.

BESIDES being thoroughly cooked and readily digestible, Pablum supplies essential vitamins and minerals, especially vitamins A, B, E, and G, and calcium, phosphorus, iron, and copper. It is a palatable cereal consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, and salt.

*Reprint of Ross and Burrill paper sent on request of physicians.

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Sixth Annual Medico-Military Symposium at the Mayo Clinic

The 1934 Medico-Military Symposium for Medical Department Reserve Officers of the Army and Navy will be held at the Mayo Clinic, from October 7 to 20, inclusive.

This is the sixth annual inactive duty training course to be held at the Mayo Clinic and will follow the plan which has proved satisfactory in past years. The morning hours will be devoted to attending clinics on subjects selected by the student officers, and the afternoon and evening hours given over to work in medico-military subjects. The medico-military program will be under the personal supervision of Colonel Kent Nelson, M.C., U. S. Army, Corps Area Surgeon, Seventh Corps Area, and Captain J. B. Mears, M.C., U. S. Navy, District Medical Officer, Ninth Naval District.

The staff and faculty of the Mayo Clinic have placed their facilities at the service of the government in the interest of preparedness and have extended an invitation to all the service to participate.

The general motif of the medico-military part of the symposium will be "Public Health and its Relation to National Defense". The problems of administration in military service presents features not dealt with in private practice. In the great field of sanitation as applied to military service, the medical officer has a distinct specialty. This course offers valuable and interesting training for the medical officer in all the components of our national defense. A program of a practical nature has been carefully compiled and the speakers selected for their ability to present authoritatively the subject assigned to them.

Application for this course of inactive duty training should be made either to the Corps Area Surgeon, Seventh Corps Area, Omaha, Nebraska, or to the District Medical Officer, Ninth Naval District, Great Lakes, Illinois. Applications should state the character of the work the candidate desires to follow in the morning hours. One hundred hours' credit will be given those who take and complete the course. While it is desirable to attend the entire course, those whose time will not permit this may join or leave at any time and will receive credit for the hours spent in training. Uniforms are optional. No charge will be made for the course .

— OSMJ —

East Liverpool—One hundred and fifty persons including physicians and members of the Kiwanis, Rotary and Lions Clubs and the American Legion attended a banquet given in honor of Dr. W. A. Hobbs who recently celebrated his 50th anniversary in the practice of medicine.

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ANNUAL MEETING, COLUMBUS, OCTOBER 4, 5, AND 6, 1934

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AS A MEDIUM OF SERVICE TO ITS MEMBERS

OCTOBER 1, 1934 VOLUME XXX
Number 10

LAST CALL FOR 88TH ANNUAL MEETING, THURSDAY, FRIDAY, AND SATURDAY, OCTOBER 4, 5 AND 6, NEIL HOUSE, COLUMBUS!

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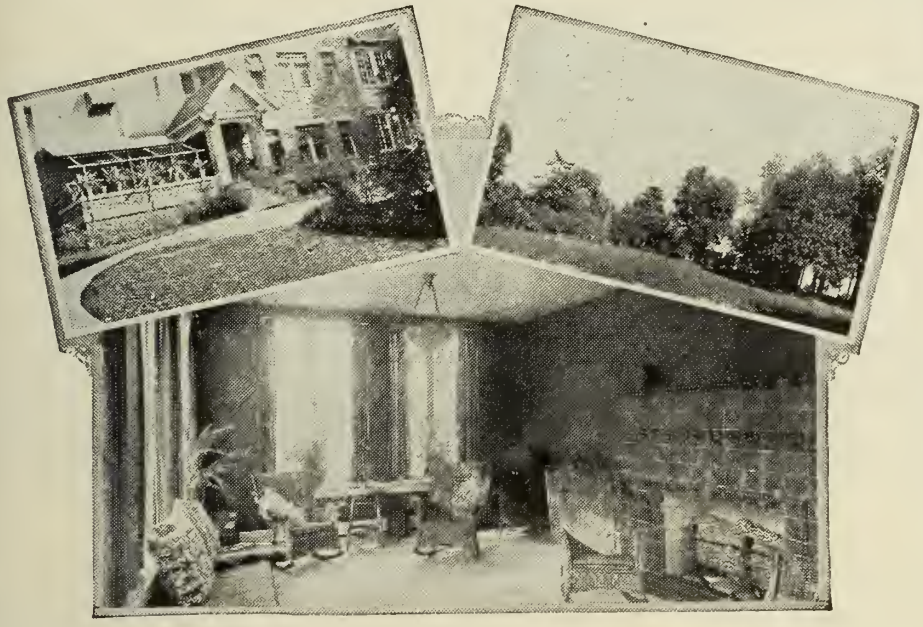
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"Grape sugar: In one-month baby, 8.6 grams per kilogram (Greenfield).

"Galactose: No accurate data.

"Levulose: (Lower for babies than adults.) One gram per kilogram (Keller).

"Maltose: Over 7.7 grams per kilogram (Reuss).

"Lactose: 3.1-3.6 grams per kilogram (Grosz).

"Cane sugar: Probably about the same as lactose (Reuss)."—*J. L. Morse, and F. B. Talbot: Physiology and pathology of the digestion of the carbohydrates in infancy, Boston M. & S. J., 164:852-855, June 15, 1911.*

1912

"Maltose has for many years been considered one of the most valuable of infant foods in modifying milk formulas; but the German school in the last few years has called special attention to the value of this sugar as a substitute for milk and cane sugars in conditions of intestinal fermentation. It is more easily assimilated and more rapidly absorbed than lactose or saccharose and it may be taken therefore by the infant in larger quantities without producing sugar fermentation."

"Maltose is especially indicated in the feeding of very young and delicate infants, and in all cases where either milk or cane sugar has produced intestinal fermentation and sugar intoxication. In the feeding of maltose it has been found advisable to combine it with about equal parts of dextrin. In Germany, and later in this country, 'Soxhlet's Nahrzucker' (which contains maltose 52.44 per cent., dextrin 41.26 per cent., and sodium chlorid 2 per cent.) has been largely used. Mead's Dextri-Maltose (malt sugar), which contains about equal parts of dextrin and maltose, is a similar preparation which may be used instead of milk sugar or cane sugar for modifying milk mixtures."—*B. K. Rachford: Diseases of Children, D. Appleton & Co., New York, 1912, p. 125.*

1913

"It is well to start with one ounce (albumin milk, or albumin-buttermilk) to every pound of body-weight in the twenty-four hours, increasing gradually until two or three ounces to the pound of body-weight are being given. Then add sugar, preferably a malt sugar, about one-fourth of an ounce at a time to the twenty-four-hour quantity, until an ounce or an ounce and a half is being given."—*J. Foote: Principles of treatment in malnutrition and atrophy of infants, Interstate M. J., 20:1913, No. 6.*

1914

"Milk sugar and cane sugar may be used in infant feeding, but my preference is for malt sugar. Mead and Johnson put up a convenient preparation which they call Dextri-Maltose and which consists of maltose 51 per cent., dextrin 47 per cent., sodium chloride 2 per cent., and which has a food value of about 110 calories per ounce."—*J. A. Gannon: Whole milk dilutions in feeding normal infants, Washington Med. Annals, 13:38-43, Jan., 1914.*

1914

"Dextrin-maltose causes the greatest gain in weight, cane sugar less, and lactose produces the least gain."—*M. S. Reuben: Observations on milk station infants, Arch. Pediat., 31:176-196, March, 1914.*

1914

"A composite opinion of the sugars is in favor of dextri-maltose, milk sugar and cane sugar in the order named."—*R. A. Strong: Essentials of modern artificial feeding of infants, Lancet-Clinic, March, 14, 1914.*

1914

"Experiments show that sugars vary in their rate of absorption, some being assimilated rapidly, while others distribute their nutriment over a longer period. For example, maltose is most promptly assimilated, cane sugar next and milk sugar slowest."

"The condition in which dextri-maltose is particularly indicated is in acute attacks of vomiting, diarrhea and fever. It seems that recovery is more rapid and recurrence less likely to take place if dextri-maltose is substituted for milk sugar or cane sugar when these have been used, and the subsequent gain in weight is more rapid.

"In brief, I think it safe to say that pediatricians are relying less implicitly on milk sugar, but are inclined to split the sugar element, giving cane sugar a place of value, and dextri-maltose a decidedly prominent place, particularly in acute and difficult cases."—*W. D. Hoskins: Present tendencies in infant feeding, Indianapolis M. J., July, 1914.*

1915

"In the severe cases (of diarrhea) he (Benson) uses Finkelstein's casein milk with malt sugar. He also believes that dextri-maltose is to be preferred to milk sugar or any other sugar, as the infants gain more rapidly and digest more easily this form of sugar."—*R. A. Benson: Observations on 1,500 artificially-fed infants, Med. Century, Feb., 1915, p. 33; abst. Arch. Pediat., 32-556-557, July, 1915.*

1915

"Until very recently we have taken it for granted that milk sugar was the best, but now many consider that malt sugar is even better. However, the malt sugar is not used in its pure state, but in the form of extracts, as dextri-maltose."—*E. B. Lowry: Your Baby, Forbes & Co., Chicago, 1915, p. 162.*

1915

"Cane-sugar (saccharose), like most of the other disaccharids, is not absorbed as such, but must first be split by the invertase of the intestinal secretion into the two glucoses, dextrose and levulose, which are readily absorbable. Maltose (malt-sugar) occupies an exceptional position among the disaccharids, in being partly absorbable as such. This is probably due to the fact that it can be split not only by the maltase of the digestive juices, but also by the same ferment being present and active in the circulating blood (Chittenden and Mendel)."

"Anticipating a little, we may mention that all cases, in which laetose may advantageously be replaced by other carbohydrates, are pathological, and without exception the result of unsuceessful attempts at artificial feeding; they will therefore be discussed under that head.

"Dextrin, intermediate between sugar and starch, is physiologically nearer to the former; we shall have oceasion to see that, under certain conditions, it may supplement sugar very advantageously. Given together with maltose, it materially delays the fermentation of the latter; Stolte observes that the more complex the carbohydrate the longer fermentation is postponed."

"All malted foods contain dextrin, and there is reason to believe that their value largely depends on their being somewhat complicated; such, at least, is the opinion of Usuki and Stolte, who believe that a mixture of earbohydrates is more slowly absorbed than a pure sugar, and therefore tends to chcek fermentation in the intestine. Southworth explains the matter more definitely, by attributing the antifermentative action entirely to the dextrin, which is not fermentable as such, but only after it has been split into maltose, a process that takes place only gradually, and in the later stages of digestion."

"I make it a rule to give the ordinary formula with dextrin-maltose whenever the usual milk or cane-sugar mixtures seem to cause excessive fermentation and eolic, or are attended with the evacuation of soap stools. I deeidedly prefer this, as a preliminary measure, to going over at once to some very low fat combination, whieh ean only be a temporary makeshift at best. I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired; in this way I have sueceeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, pp. 31, 33, 146, 158.*

1915

"The infant with diarrhea and vomiting is given nothing but tea for from twelve to twenty-four hours, no longer, and then the albumin milk is commeneed, not over 5 gm. ten times a day, with 3 per cent. of a maltose-dextrin mixture. The amount of albumin milk is inereased by 50 gm. each day until the daily ration totals 300 gm. After the weight has become stationary, carbohydrates can be added up to 5 per cent. of the maltose-dextrin mixture."

"Albumin milk is not so uniformly effectual in dysenteriform diarrhea as in cholera infantum. Whey seems to aet better, diluted half and half with oatmeal gruel. After the starvation period he gives 50 gm. of the whey and inereases by 50 gm. daily with equal amounts of oatmeal gruel. As improvement sets in 3 per cent. of a dextrin-maltose preparation can be added."—*L. Langstein: Cholera infantum and other severe diarrheas in infants, Therap. Monatsh., V. 29, August, 1915; Abst. J.A.M.A., 65:1314, Oct., 7, 1915.*

1916

"Dextri-maltose, having a higher absorption toleranee than the other sugars, is less likely to cause intestinal disturbances when large amounts of it are given."—*H. R. Mixsell: A brief résumé of the role of carbohydrates in infant feeding, Arch. Pediat., 33:31-36, Jan., 1916.*

1916

In cases of malnutrition, and indigestion in infancy, "The appetite improves rapidly, and the stools soon become normal in appearanee, if the sugars are intelligently preseribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendeney to looseness, I have used the preparation known as 'dextri-maltose,' for the extra carbohydrates; . . ."—*M. Ladd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

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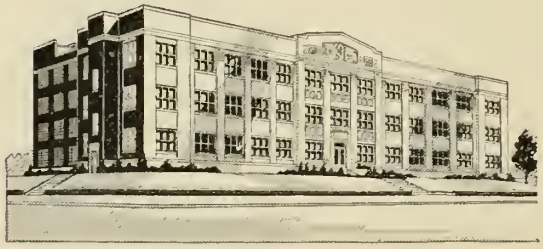
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Hoping You Will Attend the Annual Meeting

In this issue of *The Journal* will be found a general resume and final announcements relative to the 88th Annual Meeting of the State Association to be held at the Neil House, Columbus, Thursday, Friday and Saturday, October 4, 5 and 6.

An unusual amount of effort has been put forth by all concerned with arrangements and details for the Columbus meeting to make the 1934 session of the State Association an outstanding contribution to the medical history of Ohio.

From a scientific standpoint alone this year's Annual Meeting promises to establish a record. We believe those who have analyzed the Official Program, published in the September, 1934, issue of *The Journal* and after observing the splendid schedule of medical and surgical clinics planned by Columbus physicians and the tentative layout of scientific exhibits, announced in this issue of *The Journal*, will agree that the Columbus meeting will offer to the medical profession of the state an opportunity for enhancing their scientific knowledge which no progressive physician can afford to ignore.

An unusually attractive program of entertainment will be in store for those fortunate enough to be in Columbus for the meeting. The attention of the membership already has been called through *The Journal* to the annual golf tournament on Wednesday, October 3, the two evening general sessions, including the Annual Dinner sponsored by the Columbus Academy of Medicine, and the Ohio State-Indiana football game to be played on Saturday afternoon, October 6.

Those interested in the vital economic, social, governmental and organization problems confronting the profession—and every physician should be—will find the two sessions of the House of Delegates, one on Thursday morning, October 4, and the other on Friday afternoon, October 5, of particular interest and importance. Obviously, never in the history of the State Association have the official representatives of organized medicine been confronted with more complicated or more serious questions than at present. For that reason the meetings of the House of Delegates this year are of even greater importance than in the past and the official transactions at these meetings should be followed with increased interest by the membership of the Association as a whole.

All that remains to make the Columbus meeting one of the most successful and most beneficial in all respects ever held by the State Association is a large attendance of active, alert and interested members, eager to add to their knowledge of the science and art of medicine and to assist in the promotion of activities and undertakings for the benefit of the profession as a whole.

— OSMJ —

Annual Reports Are of Special Interest

It will be to the distinct advantage and benefit of every member of the Ohio State Medical Association to read with the utmost care the annual reports of the officers, the councilors, and the standing and special committees of the State Association published in this issue of *The Journal*.

Needless to say, we know of no better way for the membership to obtain a comprehensive picture of the multiple and diversified activities engaged in by organized medicine in Ohio during the past year.

In these presentations a special effort has been made to bring into bold relief the various challenges before the medical profession. Serious problems which the medical profession, and especially medical organization, must meet have been analyzed. Detailed and authentic information and data have been assembled for the information of all members, dealing with various economic, social and governmental trends and developments affecting directly or indirectly the practice of medicine.

Recommendations and suggestions for definite action by the profession are offered. Principles and policies for the guidance of individual physicians and the organized profession have been defined, reinterpreted and reemphasized. In effect, these reports constitute a textbook on policies and principles which have been and should continue to be the basis for all actions and activities of the profession.

Obviously, these reviews of activities and problems reflect the meritorious services which have been performed by those chosen by the membership to take the leadership in the affairs and functions of the State Association and the high

degree of effectiveness achieved by them, thanks to their unselfish and untiring efforts, ability to cope with complex questions and situations, and faculty of arousing cooperative and coordinated activities among the membership in general.

These records constitute an inspiring declaration on the value and importance of united, harmonious, organized effort. Without coqrdination and an attitude of unselfish service and devotion to duty, the officers, councilors and various committeemen would have fallen far short of the success they attained in handling the affairs of the State Association. At the same time they would have met with failure had they not had the active support and interest of the membership at large, indicating in no uncertain way what can be accomplished by an aroused, energetic, willing and informed group of individuals, properly organized and committed to identical ideals and motives.

If they accomplish nothing else, these reports should serve to quicken the realization of every member that the profession is confronted with its greatest crisis and that only through united action can it hope to progress and prevent unqualified and undesirable groups from establishing a dictatorship over medical activities.

— OSMJ —

Policies Tending Toward Socialism

"Relief Is Ruining My Town", is the significant headline of an article published recently in a magazine known for its presentations of current economic and governmental questions.

The article was written by Ray Bert Westerfield, professor of political economy at Yale University, following a visit to his hometown in the heart of the Middle West agricultural region; and indirectly at least, is a sermon on the importance of preserving private ownership of property and industry.

Mr. Westerfield contrasts the conditions when he was a boy there twenty years ago and those existing today. He cites several apparent reasons for what he calls the "wasting away" of his old community and why three-fourths of the population are now "on relief", emphasizinz particularly that "recent and current events are causing our people to doubt the wisdom of thrift and leading them to save less and less" and pointing out that dependence upon the state is regarded as fit, proper, common and requiring no explanation by many of the offsprings of those who had taken pride in the fact that they were self-sustaining, self-reliant, financially upstanding and independent.

Summing up his observations, Professor Westerfield says:

"With the waste of savings, the current inability to save, and the prospective want of incentive to save, our nation faces a stern reality. If private saving declines, state saving must increase, or our scale and type of industry, as well as our standard of living, must collapse, for capital rests on saving.

"The amount of dependence upon the state for a living and for security against old age, unemployment, sickness and other ills of life is growing at a terrifying pace. It is this sort of situation that promotes the trend to state Socialism and Communism. Not all Americans want an all-embracing paternalism.

"The best way, if not the only way, to quench this drift is to make it as easy as possible for the people to save, easy for them to acquire a savings fund and property in land, buildings and securities upon which they may rely for security against the contingencies of life. *Doles may ameliorate wants and quiet agitation, but they foster rather than cure the basic disease.* The true means is to help the people acquire for themselves some property."

— OSMJ —

A Public Estimate of Medicine

Too frequently in the past few years the assertion has been made that the medical profession is losing a considerable portion of the prestige, influence and public confidence which it has enjoyed throughout the ages and that something radical must be done about it.

Numerous and varied reasons have been cited for this alleged state of affairs. Naturally, the question has been debated pro and con with one side maintaining that the profession has fallen in the public's esteem; the other contending that, although changing conditions may make it seem different, the medical profession still is in as strong a position as it ever was with respect to prestige and influence.

Although it may not prove a thing, an experiment conducted in a southern college of agriculture and engineering to determine the social status of some 25 occupations, trades and professions is an interesting sidelight to the question of where the physician stands in the eyes of the public.

A group of 648 men students of the university took part in the study. Each was furnished three lists of 25 occupations and was instructed to rank the occupations according to social contribution, social prestige and economic return.

When tabulated the answers showed:

The physician in second place in social contribution, being outranked by the clergyman.

The physician in second place as to social prestige, being outranked by the banker.

The physician in third place as to economic return, being outranked by the banker and manufacturer.

Commenting on this study in an Eastern medi-

cal journal, W. A. Anderson, of the Cornell University Agricultural Experiment Station, pointed out:

"No other of the group of 25 occupations is ranked so consistently at the top. The clergyman is ranked first as to social contribution, third as to social prestige, but dropped to sixteenth in economic return. And each of the other occupations that are ranked near the top show this same result. But the attitude toward the physician is consistent in all three respects. He occupies a top rung.

"Is it because youth has such a fine opinion of the contributions and prestige of this profession that the medical colleges are swamped with applicants? Or is it that the medical profession has maintained such high standards of professional practice that society has come to recognize its social worthwhileness? Perhaps both influences are at work."

Of course one should not take the results of this one inquiry too seriously. Many, no doubt, will disagree with the rankings accorded the medical profession by the student group. However, it does seem as if the combined opinion of some 600 college men with diversified interests and reared in various environments should be worth something.

It is of vital importance that the profession do everything within its power to maintain this public confidence and esteem. So long as the profession in general can hold its top ranking in social contributions, social prestige, and public confidence and respect it will be in a strategic position to maintain its economic status and preserve its independence and integrity. Temoprary maladjustments should not influence it to disregard those principles and services which have enabled it to merit and be worthy of the high degree of confidence society has in it and its work.

— OSMJ —

The Value of Skepticism

Some of the sharp criticism that has been made of the medical profession recently has been hard for it to take.

Physicians as a group have been labeled as reactionary, ultra-conservative, ignorant of social changes, short-sighted, etc., because they have failed to enthuse over the different plans and schemes that have been hatched by theorists and brain-trusters for making over the present system of distributing medical services.

Like other humans, physicians have no desire to be unpopular. Nor do they relish incurring unnecessarily the antagonism of anyone. On the other hand, the majority of the medical profession is not as yet convinced that the profession should sacrifice what it believes to be sound principles and a policy of thoughtful investigation and careful experimentation as pre-requisites to definite commitment in order to win temporary popularity.

With respect to the social and economic aspects of medical practice, the average physician finds himself in about the same position as Merle Thorpe, the straight-thinking editor of *Nation's Business*, who when taken to task by a subscriber for his skepticism, admitted that he hated to be unpopular but was unable to work up any enthusiasm over many of the sugarcoated schemes suggested as solutions for economic and social problems.

Here is Thorpe's answer to his critic and in it there is considerable encouragement for physicians who have refused to be stampeded by medical reformers:

"No one likes to be unpopular," Thorpe writes. "It is easy to be popular in discussing national questions by suggesting solutions 'easy to take'.

"Here is a popular prescription: Guarantee a world without risks, without illness, without death or taxes, a world in which every day would be Christmas and Santa Claus would remember all of us, not according to our deserts, but according to our wishes.

"I could advocate a program as popular as any. I could urge *desire* rather than *merit* should rule the size of our incomes; that loss and failure be stricken from our business language and that profits and dividends be the sole text of commercial reports, with everyone on a job to his liking. I could demand that we all remain forever young, that old age be abolished, that debts be outlawed, that pensions should sustain us without occasion for toil or trial of mind and spirit.

"It would be popular to denounce fire, flood and hurricane, drought and disease, and all other misfortunes that make life the interesting speculation that it is. I could say, let us have no more ambition, for that means competition; let us not try our wings in the world for fear of a fall.

"I could plead the desirability of eating our cake and having it, too. And it would be popular to propose a law which would regulate the weather, keep the rain and the sunshine in proper proportion, and make every crop a bumper yield, with no hazard of failure and no surpluses.

"But it is never the realist who gets the acclaim of the populace. As a practical economist who has had to meet pay rolls the greater part of his life, I mistrust the mirages held up to view by so many men, most of them honest in their views. But I believe that we grow by what we feed on, and that, as the level of national intelligence rises, the idea of substituting paternalism for individual responsibility will ultimately give way to common sense.

"Unpopular is may be, but the truth remains, that no permanent success will come to the nation until it comes to the individuals who make up that nation. And it will come to those individuals in direct proportion to their active curiosity about the unknown in economic life—the unknown in manufacturing, in financing, in retailing and in its active application to the unawakened desires of men and women.

"And I know of no legislation which can arrest the yeasty ferment that makes people want to get on and up in the world, to try their hands at this or that without paternalistic chart and compass."

A STUDY OF THE PATHOGENESIS OF SOME ULCERS OF THE COLON*

By MARSHALL O. BOUDRY, M.D.,[1] and J. ARNOLD BARGEN, M.D.[2]

ROCHESTER, MINNESOTA

THE often haphazard use of the term "colitis," our observation of many cases of diarrhea of undetermined origin, and the repeated observations at necropsy of ulcers in the colon, without adequate explanation, led to an intensive study of cases of nonspecific ulceration of the colon. The subject was approached from the clinical and from the postmortem standpoints. The records of 525 cases encountered at The Mayo Clinic, in which were available complete clinical data and data obtained at necropsy, as well as pathologic material, were carefully examined. We attempted to determine the frequency, nature, and origin of some of the colonic ulcers of uncertain etiology, and to correlate their pathologic variations with clinical signs and symptoms. This study does not include cases of ulcerative lesions of the colon of definitely known etiology, such as chronic ulcerative colitis (diplostreptococcal type), bacillary dysentery (Flexner and Shiga bacilli) tuberculosis, amebiasis, Asiatic cholera, syphilis, actinomycosis, or colitis caused by Balantidium coli. Nevertheless an etiologic classification will be attempted.

ETIOLOGIC CLASSIFICATION

The nonspecific ulcerations of the colon are considered under five headings: (1.) Those resulting from obscure metallic poisoning, such as that caused by mercuric chloride, mercurochrome, metaphen, and arsenic; (2.) Those which follow stasis of the colonic stream, which may result from benign, malignant or inflammatory lesions within the lumen of the colon, or lesions that produce stasis by external pressure; the fecal content of the colon may through dehydration become firm enough to cause partial obstruction with or without ulceration; (3.) Those which accompany uremia; (4.) Those which are found in the presence of overwhelming septic states, and, (5.) Those which seem to develop from a pseudomembranous type of colitis. Studies of the fifth type, it should be said, were based on material not included in the 525 cases on which studies of the other four types were based.

OBSCURE METALLIC POISONING

Mercury.—In 1878 Heilborn experimented on rabbits and dogs to determine the effect on the colon of poisoning by mercuric chloride. Ulcerative lesions of the colon developed in the majority of the rabbits. These lesions were not as common in the dogs, and the author explained this on the basis of anatomic differences between the alimentary tracts of the two animals. He concluded from his studies that the ulceration was due to the mercury being excreted by the mucosa of the colon for he noted many black granules about the mucosal blood vessels that could not be accounted for by fixing solutions or stains, and suggested that they might be sulphide of mercury. This view was confirmed by Flexner and Sweet in 1906, by Almkvist in 1906, and by Weiler in 1913. Bissel described black granules similar to those seen in the colon in the polymorphonuclear neutrophils of the blood stream.

In 1917 Burmeister and McNally confirmed the work of Bissel and the former workers, and suggested again that ulceration of the colon results from the excretion of mercury through the mucosa. Flexner and Sweet, in proving the pathogenesis of their bacillus, showed quite conclusively that mercuric chloride and ricin are excreted by the liver in the bile, to be reabsorbed by the small bowel and again excreted by the same process. This forms a vicious cycle and prolongs the time of excretion through the mucosa of the colon. Flexner and Sweet interrupted this cycle by a permanent biliary fistula to find that lesions of the colon did not develop, but the animal died just the same. The prolonged time of excretion of mercuric chloride, by the colon, they held responsible for the ulcerations of the colon.

Peterson, in comparing the toxicity of the various compounds of mercury, divided them into four groups, placing mercuric chloride in the most toxic group and mercurochrome soluble (disodium salt of 2:7-dibromo-4-hydroxymercurifluroescein) in the least toxic group. The minimum lethal dose of mercuric chloride for man, if given intravenously, was estimated at 5 mg. for each kilogram of body weight; for dogs it was found to be 4 mg. Todd found that the minimum lethal dose of mercurochrome for rabbits was about 25 mg. for each kilogram of body weight.

Mercurochrome came into use about 1919, chiefly after Young's reports. It contains about 25 per cent of mercury, and it is the presence of this metal that started the controversy concerning its relation to ulcers of the colon. Young, clinically and experimentally, has proved to his

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satisfaction that the drug is safe to use in doses up to 5 mg. for each kilogram of body weight.

Young and Hill found transitory diarrhea among children who were treated with mercurochrome for septicemia, and slight colitis at necropsy only when the drug had been administered recently.

Baldwin noted catarrhal colitis among rats that had received 6 to 8 cc. of a 0.5 per cent solution of mercurochrome subcutaneously. Mendelson commonly found bloody diarrhea among rabbits used in experiments but did not say anything about finding lesions in the colon at necropsy.

Wade described a case of progressive stomatitis, nausea, diarrhea, and acute nephritis that developed in a human being. This resulted after a 5 per cent solution of mercurochrome had been administered three times a week for about three weeks in doses of 1 ounce (30 cc.), into a draining abdominal fistula.

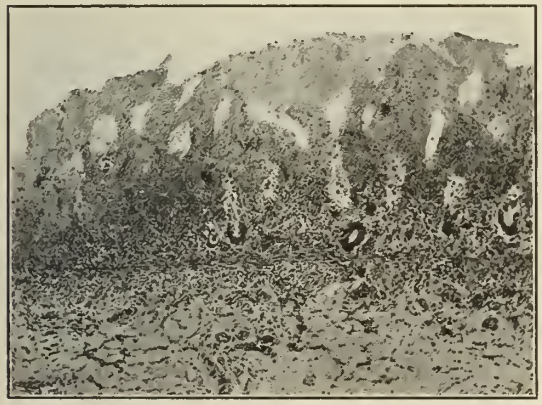


Fig. 1. The outstanding finding is necrosis of the mucosa. The cellular infiltration is not marked. The capillaries are thrombosed.

Bargen, Mann and Osterberg found that mercurochrome and metaphen are neither excreted nor absorbed from the isolated colons of dogs in a period of four hours. Hill and Scott, and Snell and Hench found that mercurochrome injected into the blood stream was excreted by the bile, and Roeder and Judd noted its appearance in vomitus and feces. We have made similar observations.

Metaphen is another organic compound that is considered less toxic than mercurochrome. It contains from 58 to 60 per cent of mercury, firmly bound to the carbon atom about the benzene ring. It is given intravenously for septicemia. The dose is 10 cc. of a 0.1 per cent solution, which would contain about 6 mg. of mercury.

Two cases of poisoning from mercuric chloride are included in the cases we studied. One patient died within twelve hours after taking a huge amount of the drug which produced corrosive lesions throughout the gastro-intestinal tract. The second patient was poisoned by three tablets of mercuric chloride that remained in the stomach for forty minutes before gastric lavage. The course of the illness was six days and diarrhea, anuria and uremia were present. The value for urea rose to 288 mg. and that for creatinine to 13.2 mg. in each 100 cc. of blood. Ulceration was present throughout the colon. The mucous membrane was bluish, with ulceration of the mucosal type. Microscopically, edema, thrombosis of the mucosal capillaries, and necrosis, could be demonstrated (Fig. 1).

To determine the number of patients who came to necropsy, who had received mercurochrome in the last ten years, 438 histories were selected from the files, in which diagnoses of septicemia, pyemia, sepsis (other than peritonitis), or acute or subacute pyelonephritis had been made. In this group, seventy-seven patients had received mercurochrome, and forty-four had ulceration of the colon. Ulceration of the colon did not occur among fifty-two of the seventy-seven patients who had received mercurochrome, whereas ulceration did occur among twenty-five of the seventy-seven patients. Roughly, one of every four patients who received mercurochrome had ulcerative lesions in the colon.

As the exact period of time that is necessary for mercurochrome to produce ulcerations in the colon is not known, the cases in which ulcer was present were first reviewed, with the assumption that twenty-four hours was sufficient time, and second with the assumption that three to six days were necessary. Microscopic slides were available in twenty of the twenty-five cases. If ulceration can result within twenty-four hours after administration of mercurochrome, the lesion present should be acute; hence, lesions which appeared to be of longer duration were excluded. This eliminated eleven cases; therefore, ulceration in nine of the colons may have resulted from the mercurochrome in twenty-four hours. Further study of these nine cases revealed that in three blood culture was positive for microörganisms, and that in one case the value for urea was 348 mg. in each 100 cc. of blood before death; consequently these four cases were excluded, and five remained.

As has been said, the twenty cases were again reviewed on the assumption that mercurochrome could not produce ulcerative lesions in the colon until three to six days had passed since the time of administration. This excluded the cases in which patients had received mercurochrome within three days before death. To be accepted, the lesions must appear, microscopically, to be very recent on the third to the sixth day after the injection of mercurochrome. Eleven cases were eliminated on this basis, which left nine. Three more cases were excluded, as in two the blood cultures were positive and in one the value for urea was 202 mg. in each 100 cc. of blood before

the patient died. This reduced the number of cases to six.

Some interesting features were observed among the fifty-two patients who received mercurochrome and did not have ulceration of the colon. In 32 per cent, bacteria were grown from the blood before the patients died. Blood cultures were positive in the same percentage in the group of twenty-five cases in which ulceration occurred. In two of the fifty-two cases the value for urea was respectively 104 mg. and 122 mg. in each 100 cc. of blood, and the blood culture was positive. The former patient received 10 cc. of 1 per cent mercurochrome eight and two days before death; the latter, 10 cc. of 1 per cent mercurochrome three days before death. In these two cases, three possible etiologic factors occurred, yet ulceration was not found in the colon.

Injections of 1 per cent solution of mercurochrome were used. As the mercury is held responsible for producing the ulceration in the colon, the following figures are expressed in milligrams of mercury present in mercurochrome. In the group of twenty-five cases in which ulceration occurred, the average total dose was 41.1 mg. of mercury. The amounts administered varied from 25 mg. of mercury (10 cc. of mercurochrome) to 62.5 mg. of mercury (25 cc. of mercurochrome). The average total dose in the group of cases without ulceration was 44.42 mg. of mercury. The dose varied from 12.5 mg. of mercury (5 cc. of mercurochrome) to 112.5 mg. of mercury (45 cc. of mercurochrome). The largest single dose, however, was 30 cc.

The presence or absence of diarrhea is the essential symptom referable to the colon in this group of cases, and the only symptom found with sufficient frequency to record. Urgency, the type of stool, and abdominal cramps were recorded very rarely. A case did not seem worth considering when fewer than three stools occurred a day. A case was reviewed when three or more stools were passed daily. Such diarrhea might be constant or intermittent. In the majority of cases, the daily stools never exceeded seven, and in not more than two cases did the patients pass ten to fifteen stools.

Of the seventy-seven cases in which mercurochrome was given, in 32 per cent diarrhea was present, and in 68 per cent it was absent. Of the forty-four patients who had ulceration of the colon; 28 per cent had diarrhea and 72 per cent had not. Of the fifty-seven patients who did not have ulceration of the colon; 33 per cent had diarrhea and 67 per cent had not.

Comment on results of poisoning by mercury.—Mercuric chloride definitely produces ulceration of the mucosa of the colon; hence, mercury in any form may be thought to produce similar results. It seems unlikely that mercurochrome given in the amounts stated could, with any considerable frequency, produce ulceration of the colon, as the minimum lethal dose of mercuric chloride given intravenously to man is estimated to be 0.2 gm., and the average dose of mercury in the mercurochrome given to patients with ulceration of the colon who received mercurochrome was 0.041 gm.*

Arsenic.—Arsenic has never been mentioned as producing ulceration of the colon and experimental work on this subject is lacking. Gastroenteritis is the common gastro-intestinal lesion. Of ten patients whose deaths were due to arsenical poisoning, either direct or indirect, two had nonspecific ulceration of the colon. It is interesting to note that exfoliative dermititis was present in both cases. One patient died in six days with pronounced uremia; the condition of the other was indicative of toxemia for six weeks. Of the eight patients who had no colonic ulceration, four died in thirty-six hours. Three patients died after four, eighteen and sixty days, and one patient died one year later from arsenical cirrhosis of the liver.

STASIS OF COLONIC STREAM

Conditions which cause obstruction will be considered under this heading. Obstruction may occur from benign, malignant or inflammatory lesions within the lumen of the colon, or from lesions that produce obstruction by external pressure. The fecal content of the colon may, because of dehydration and bulk, become firm enough to produce partial stasis. Ulcerative lesions of the colon have been associated with the conditions mentioned. There is a paucity of information in the literature on the subject of intestinal stasis with ulceration. The standard textbooks on pathology mention that catarrhal ulceration of the colon may result from constipation and may be found in conjunction with obstructive colonic lesions. Higgins found in three of the six dogs in which obstruction was successfully induced, just above the rectosigmoid, that ulceration of the mucosa developed. In two dogs, observed after twenty-six and twenty-seven days, respectively, shallow mucosal ulcers were present. In one dog, observations were made after five days, and hemorrhagic lesions had developed that suggested pseudomembranous colitis.

With these possible etiologic factors in mind, twelve cases were selected from the records of necropsy in which obstruction was present in the rectum or sigmoid of sufficient degree to dilate the walls of the colon. Ulceration of the mucosa was present in four of the twelve cases. Of these cases in which there was ulceration, in two obstruction was complete, and in two was almost complete. The lesion in each case was malignant.

Of the group of eight cases in which ulcers

*Bichloride of mercury contains 73.9 per cent mercury (Osterberg).

were not found, in six obstruction was not quite complete, while in two it was. The lesion was malignant except in one case, in which a dense fibrous band had constricted the sigmoid.

UREMIA

There is little in the literature that deals directly with ulceration of the colon occurring at the same time as uremia. In textbooks of pathology it is mentioned, briefly, that ulceration of the mucosa of the colon may occur terminally in cases of nephritis, but it is not stated that the uremia is associated with the ulceration. Streicher was successful in producing uremia in the dog by intravenous administration of urea, and he noted that edema of the small bowel was constant, and that "nonulcerative enteritis" occurred. No mention was made as to changes in the colon.

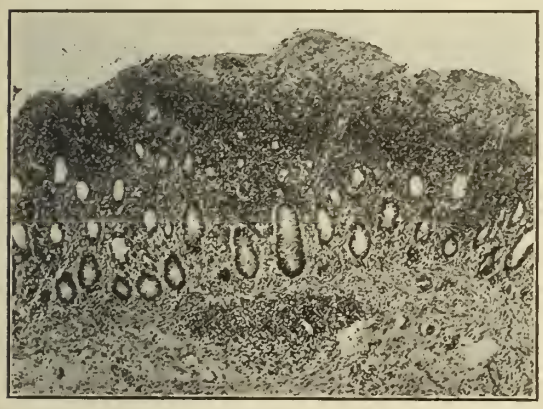


Fig. 2. Marked infiltration of polymorphonuclear neutrophils and lymphocytes is present in the upper two-thirds of the mucosa. The glands in this region are disappearing. Fibrin is present superficially.

Forty records of necropsy were available, relative to cases encountered from 1925 to 1932, in which uremia was the chief factor in causing death. The uremic state was clear cut, for coma and convulsions had occurred, and laboratory data were satisfactorily definite. The organic lesions were acute, subacute and chronic nephritis, polycystic kidney, hypertension graded 4, malignancy of the kidneys, and ureteral obstruction from malignant growths. In this group of forty cases, in which the immediate cause of death was, so to speak, "uncomplicated uremia," in five there was ulceration of the mucosa of the colon (Fig. 2).

The history relative to the colon in the five cases in which ulceration was present is interesting in that in only one case was diarrhea marked, twenty-two stools daily. The diarrhea began eight days before the patient's death, and was readily controlled to five stools daily by medication. Two patients had four to six stools daily without blood. One patient was constipated throughout the entire course of the disease and another had stools involuntarily. The degree of uremia, as measured by the value for blood urea, was about the same in the group in which there was ulceration as in the group in which there was none.

GENERAL SEPSIS

As bacteria play a definite part in some forms of enteritis and chronic ulcerative colitis of diplostreptococcal type, it is reasonable to assume that they may be factors in some other ulcerations of the mucosa. In both of the foregoing groups, it is possible to demonstrate the presence of bacteria in the mucosa, but in the latter group they occur throughout the wall of the bowel as well.

Of the cases reviewed, 438 were loosely classified under the heading of sepsis. In this series, sepsis is understood to include cases in which death is due to an overwhelming infection, exclusive of generalized peritonitis. The factors that may produce ulceration of the colon are multiple in this group, and seventy-seven patients received mercurochrome intravenously. In only 10 per cent of the cases there were nonspecific ulcerative lesions of the colon; therefore, little significance can be attached to general sepsis as an etiologic factor in the ulceration.

PSEUDOMEMBRANOUS COLITIS

The finding of a pseudomembranous type of colitis is not recent. Virchow described it in 1853, at which time he summed up the literature and added his opinion. He felt that some agent was present in the feces that acted locally to produce colitis. He reiterated his views in 1871. He found that the lesion may be present in fatal cases of phthisis, pneumonia or endocarditis and that it may appear very unexpectedly with no clinical findings to point to its presence.

Little has been done since Virchow's time to explain the possible etiology of this type of colitis. To study the cause of the pseudomembranous colitis, thirty-one cases were chosen from the files of the pathologic laboratories (1924-1931) in which there was the typical picture of mucosal inflammation with marked formation of a pseudomembrane. In this group, the average age of the patients was fifty-nine years; the youngest patient was twenty-four and the oldest eighty-one. Nineteen were males and twelve were females, or 62 per cent and 38 per cent, respectively. The history relative to the colon is interesting, as in no instance was diarrhea marked. Fourteen patients (48 per cent) were constipated. In fifteen cases slight diarrhea, from three to seven stools daily, developed. The stools were described in a few instances as being small and liquid, no blood or pus being present. Tenesmus and cramping were apparently absent, as they are not mentioned. In the remaining two cases movements were involuntary. These data were

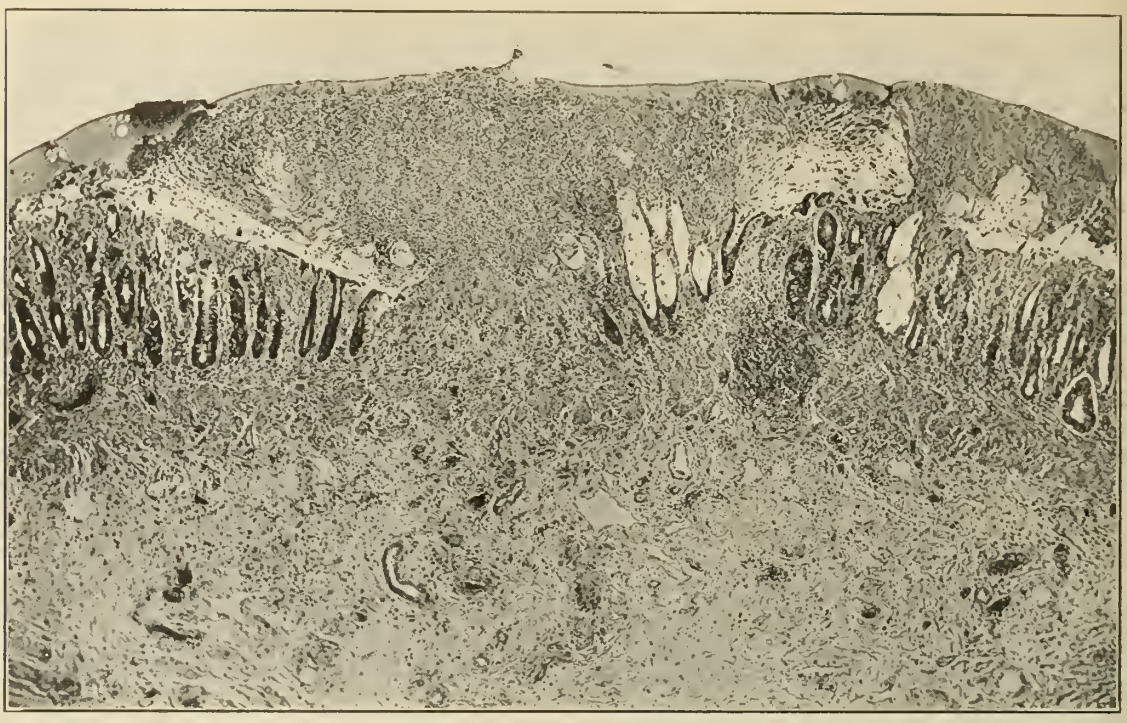


Fig. 5. A cross section of a pseudomembrane. The mucosa in the center is the seat of intense inflammatory reaction, as evidenced by the amount of fibrin and cellular exudate that is spreading over the normal mucosa (the clear staining superficial edge is gelatin).

obtained from the bed-side notes taken before the patient died. The possible etiologic factors that may have been responsible for producing pseudomembranous colitis in these cases are often many. The value for urea varied from 100 to 348 in each 100 cc. of blood in eight cases; the cultures of the blood were positive in three cases; mercurochrome was given in nine cases; a turpentine enema was administered in one case, and there was one case of obstructing diverticulitis, one of fatal exophthalmic goiter, one of acidosis, and one of alkalosis. In twelve cases, two or more of the foregoing factors were present. This illustrates the multiplicity of factors present at the time of death, and why the term "pseudomembranous colitis" may be modified by many different etiologic adjectives, such as uremic colitis, mercurochrome colitis, catarrhal colitis, and so forth. It would be better to classify this type of colonic disturbance as pseudomembranous colitis, and to disregard the etiology until more definite facts are known.

Microscopically, the injury is primary in the mucosa. In the lesions beginning inflammation may be noted as evidenced by a line of polymorphonuclear leukocytes immediately below the basement membrane of the lining epithelium. As this lesion advances, an excessive amount of fibrin forms, which spreads over the mucosa. It is this marked presence of fibrin that especially characterizes the psedomombrane. In Figure 3 a well formed pseudomembrane is seen. The pathogenesis of this type of exudate is not well understood. Later, when erosion of the mucosa occurs, the lesion becomes a true ulcer. Theoretically at least, symptoms and signs of disturbance in the colon should then appear. This sequence of events may account for its absence in the early stages of diarrhea, and other clinical symptoms and roentgenologic signs of disturbance in the colon.

COMMENT

If similar etiologic factors had been found in 50 per cent or more of these cases, the results might be significant. The uncertainty of the etiology suggests our very meager knowledge of the physiology of the colon, and the factors that produce inflammation in this organ. Flexner and Sweet offered a lead from their work on biliary fistula. They observed that ulceration of the colon rarely occurred in dogs poisoned by intravenous injections of rich, mercuric chloride or toxins from the Flexner bacillus, when a permanent biliary fistula was present. This would indicate that these drugs were excreted by the biliary system before reaching the colon, or were detoxified by the liver.

One important clinical factor that is brought out by these observations at necropsy is that ulceration of the mucosa may be far from benign. It has been found to play a major adverse part in the patient's fight for life, by causing perforation with peritonitis, abscess, or formation of

a fistula. These complications would give symptoms and signs, and a diagnosis could readily be made, but without perforation the entire mucous membrane of the colon may be severely inflamed, with no clinical evidence except mild diarrhea without passage of blood or pus. Proctoscopic examination would be of limited aid, and as yet no roentgenologic evidence is available for pseudomembranous colitis. This latter diagnostic procedure may be impossible to perform because of the patient's condition.

It is doubtful if mercurochrome produced ulceration of the colon in the group studied. The evidence for it is very meager. The dose of mercurochrome was very small, and its toxicity is considerably less than that of mercuric chloride. On the other hand, it has not been proved that mercurochrome did not produce ulceration of the colon in some instances.

The group of cases studied, in which uremia was present, were extremely interesting. The uremic state was not complicated by the presence of other etiologic factors considered here. Uremia may be the cause of ulcerative colitis, but it seems strange that such ulceration occurred in only 12 per cent of forty cases of uremia.

When stasis of the colonic stream is present, ulceration of the mucosa may occur. Higgins offered experimental evidence of this in dogs in which obstruction was complete, and tentatively explained it on a basis of "obstructive pressure" within the colon. It is likely that feces may contain material that if dehydrated sufficiently could injure the mucosa of the colon. This would be traumatic ulceration, which could occur from any solid substance, such as glass, steel or bone.

Sepsis is probably not a direct etiologic factor in the production of nonspecific colitis, as considered here. Ulceration of the colon occurred in only 10 per cent of the 438 cases reviewed. The presence of bacteria as a secondary invader is important. Although, perhaps, no startling or new additions have been made by this study of ulcers of the colon, it has crystallized some of our ideas on the subject. We hope the investigation may be a stimulus to others, as it has been to us, for more intensive study of these lesions.

SUMMARY

Many causes of ulceration of the colon are now known; these are: poisoning by mercuric chloride, trauma, bacillary dysentery of the Flexner and of the Shiga type, Asiatic cholera, syphilis, actinomycosis, Balantidium coli, Endamoeba histolytica and the entity known as chronic ulcerative colitis (diplostreptococcal type).

Mercurochrome given intravenously in amounts from 10 to 25 cc. of 1 per cent solution was accompanied by ulcers in the colon in about 7 per cent of cases.

Arsenic probably is not a factor in ulceration of the colon.

It is likely that ulceration of the mucosa will develop in the obstructed colon, as this occurred in 33 per cent of the cases studied.

Uremia was observed to be associated with ulceration of the colon in 12 per cent of the cases.

Clinical evidence of pseudomembranous colitis is often inadequate. The lesion may be discovered at necropsy, without antemortem signs or symptoms of disturbances in the colon. This may be explained by the fact that real ulcers had not yet developed.

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— OSMJ —

A new biography of Dr. Benjamin Rush, distinguished physician and citizen of the Revolutionary War period; signer of the Declaration of Independence, and one of the greatest medical teachers in American history, has been written by Nathan G. Goodman and recently published by the University of Pennsylvania Press.

THE TOXEMIAS OF THE LATER MONTHS OF PREGNANCY

By JOSEPH T. SMITH, M.D.,

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MEDICINE has its short-lived fads. By turn, we focus our attention on humors, then bacteria; on appendix, tonsil, tooth, or vitamin. The present enthusiasm blames or blesses the mysterious hormones for most of the activities of the human body. So, a most illuminating present-day conception of these toxemias of pregnancy is based on hormonology. A fascinatingly attractive idea but it must be approached with caution because, influenced by the *zeitgeist*, we may not be able to place a true value on the theory today.

An excellent presentation of this theory of the hormone etiology of the toxemias has come from the pen of Hofbauer. We know that the chorionic villi give off foreign proteid and syncytial cells into the mother's circulation. The total area of all the villi is estimated to be 6.5 square meters. A large amount of material must come from such a great area. The impact of this flow of foreign proteid upon the liver cells first stimulates them, and later causes some passive congestion and hepatic insufficiency. We know that healthy liver tissue has the power to destroy toxins and such hormones as adrenalin. It can also absorb and destroy the pressor substance from the posterior pituitary lobe. This posterior pituitary also yields an anti-diuretic principle; and a dysfunctioning liver cannot properly remove either substance from the blood stream. A hormone from the thyroid is also allowed to accumulate in the blood as a result of poor liver function, and this seems to have the power to increase the activity of the pituitary pressor hormone.

Pituitary extract, in animal experiments, seems to interfere with the ability of the tissues to utilize oxygen; so a sort of "internal asphyxia" results when this hormone accumulates in the blood. An increase of lactic acid formation, lowered CO_2 combining power, and an increase of inorganic phosphorus result. This is a determining factor in eclampsia: reduced tissue oxygen injures the myometrium.

In passing, we may mention that Dr. Harvey Cushing shows that, in eclampsia, there is a basophylic invasion of the posterior lobe of the pituitary, with secretory products traced to the tubular nuclei. Some think that foreign proteids from chorionic villi stimulate the pituitary to increased excretion, enlarging a load of hormones that is already too great for the damaged kidney to remove efficiently from the blood.

We note a final effect of the inability of the liver to get rid of circulating hormones. Increase of adrenalin increases the permeability of the vessel walls. In experiments, one-fifth of a normally toxic dose of strychnin will cause convulsions. So we get oedema of the brain and excessive irritation of the nervous system.

In this connection, it is significant that the quantitative Aschheim-Zondek tests show a marked increase in cases of eclampsia. Do not forget, however, that this test shows the urine content; and that the hormones involved probably come from the *anterior* lobe of the pituitary gland—not the posterior.

The whole matter reduces itself to a vicious circle. Foreign proteid from the villi affects the peripheral liver cells. Loss of liver tissue lowers the power to destroy pituitary and other circulating hormones. The resulting oxygen lack, anti-diuretic effect, and vaso-constriction give rise to the kidney features and to the general classic picture observed in these toxemias. By the bilirubin injection test, it is estimated that 40 per cent of all pregnant women past the fourth month have some deficiency.

We divide these toxemias into nephritic and pre-eclamptic types. Probably there is little real difference. In individuals with latent or active kidney disease, the nephritic features are more marked and more apt to persist into later life; but the fundamental cause is probably the same in both types. The condition of such patients long after delivery has been a matter of study in recent literature. Both Stander and Peckham have presented statistics to prove that about 40 per cent of all women having nephritic toxemia are dead at the end of ten years. It is shown that 40 per cent of all patients passing through a toxic pregnancy have some degree of resulting nephritis in later life. The earlier in pregnancy the toxemia develops, the greater the chance of permanent nephritis, and the greater the percentage of dead babies. If the toxemia started four or more months before term, 66⅔ per cent of the babies died; but only 7½ per cent were lost if the symptoms had first appeared one month or less before the child was due. These authors claim that 25 per cent of the babies are doomed in the cases of nephritic toxemia. The conclusion reached by these writers is that when toxemia develops early, the labor should be induced promptly. The chance for the child's life is so poor that one is not justified in subjecting the mother to the grave

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risk of permanent kidney injury for the problematic sake of the child.

With these rather pessimistic ideas in mind, we have reviewed the patients admitted to Maternity Hospital during the years 1932 and 1933. There were 4053 such admissions; and of these, 145 had symptoms marked enough to justify a diagnosis of some grade of toxemia, and at the same time were past the sixth month of pregnancy. There were two cases of later toxemic vomiting. Forty-five were of the nephritic type; 87 were pre-eclamptic; and 11 were true eclamptics, with convulsions.

In pitiful contrast to the normal hospital fetal mortality of less than 5 per cent, we lost, in this group of toxemias, 16 per cent, or 23 babies. It was even worse when the symptoms began at or before the eighth month, for 30 per cent of such babies perished. In only three cases in which the blood creatinin was estimated was it above 1.5. In all three of these cases, the baby was dead. There is a striking ascending scale of fetal death in the three types of toxemia. Of the pre-eclamptic group, 11 per cent died. Of the nephritics, 18 per cent were lost. Of the eclamptics, 50 per cent perished.

The blood pressure figures also show some interesting facts. The average maximum systolic pressure for the whole group of 145 cases was only 155m. Yet of the cases where the baby died, the pressure averaged 163m. Peckham states that 25 per cent of the babies are lost when the systolic pressure goes to 210m. The types of toxemia also give us an ascending scale of average systolic blood pressures. The vomiting cases show only 129m. Then come the pre-eclamptics, with 147m. Next, the nephritics, 166m. And finally the eclamptics, averaging 175m.

As far as possible, we discovered the present condition of these toxemic patients. Forty-eight per cent are well; 50 per cent show more or less evidence of nephritis; and 2 per cent are dead.

Of those with pre-eclamptic toxemias, 69 per cent are well today; and 30 per cent are nephritic. One died.

Of the nephritic toxemias, only 11 per cent now seem quite well, while 89 per cent show signs of kidney damage.

Of the true eclamptics, 27 per cent are well; 55 per cent are nephritic; and 18 per cent are dead.

What should we do with such patients? In view of these late results, it does seem as though we should empty the uterus promptly if any of the following conditions are present:

1. The toxemia has begun early; before the eighth month.

2. The toxemia is definitely of the nephritic type.

3. There is marked blood retention of creatinin and nitrogen.

4. The blood pressure is high.

We may be getting away from the Stroganoff idea. Mere quiet and use of sedatives will not break the vicious circle to which I have referred earlier, though such methods may guard the nervous system temporarily. I greatly regret that I have no magic pill to offer for the sure cure of these toxemias—no drug, harmless to the human tissues, that will destroy these excess hormones circulating in the blood of the nephritic or eclamptic patient. Granting that this view of the etiology may be correct, there are three points of attack towards which we may direct our treatment:

1. Fight the poor tissue oxygenation. The best way to do this is by the use of hypertonic glucose injections, and by the direct inhalation of oxygen if the condition is severe.

2. Attack the deranged water metabolism. Some recommend the restriction of the fluid intake, but we cannot see the propriety of this, in view of our experience. Instead, fluids should be urged, even given by infusion if necessary; and removed by means of sweating in hot packs, and by saline cathartics. Again, intravenous glucose solution is of great value; 250 cc. of a 20 per cent glucose may be given, replacing 300-350 cc. of blood that has been withdrawn by venesection.

3. The vasospasm is fought with morphine and the glucose. It is possible that ultra-violet rays may aid in destroying the circulating hormones. Alkali, such as sodium bicarbonate, may be of value, and it can be given in an infusion consisting of a 1000 cc. of water containing 2 G. of the bicarbonate. Obviously, pituitrin should not be used for these patients.

None of these methods are more than slight helps, however; these is no cure in them. If the symptoms remain alarming, there is only one thing for the conscientious physician to do—empty the uterus in the manner that will cause the least trauma and shock. In our 145 cases, labor was induced 37 times (26 per cent). If you offer any criticism, I feel that it would be that we had not interrupted pregnancy often enough; *not* that we had done so too frequently.

If Caesarean delivery be the method indicated, do not fear it unduly because toxemia is present. Twenty-three of our 145 cases came to section, and these were naturally the more severely toxic ones. Of these, one mother died, and six babies were lost.

Though eclampsia may be the only toxemia which is never seen except in pregnancy, there is a large group of diseases, also referred to as "toxemias," which do appear during later gestation, but which are also seen in the non-pregnant. Beside the rare late pernicious vomiting, the nephritic toxemia, and the eclampsia, we meet

sometimes: Excessive salivation; chorea, neuraliga; peripheral neuritis; tetany; impetigo herpetiformis; dermatitis herpetiformis; accidental hemorrhage; acute yellow atrophy of the liver; and severe anaemia, pernicious type.

Most of these "toxemias" are now considered to be due to dietary defects. The pregnant woman needs a well-balanced diet of about 3000 calories per day. In spite of the differing opinion of some writers, we are convinced that the protein should come chiefly from wheat, legumes, and other vegetables. Meat, in any large amount, should not be used. It is interesting that, in dogs, liver lesions similar to those found in eclampsia have been produced by feeding only lean meat.

The mineral needs require special attention.

First, *iron.* Normally, there are about 3 G. of iron in the body. Physiological bleeding occurs in woman, not in man, and more hemoglobin will be lost at the coming labor. Occasional blood tests are wise during pregnancy. Spinach and eggs should be eaten, and Blaud's pills employed if there is marked anaemia.

Second, mineral; *iodine.* In this goitre belt, I need not mention the enlarged thyroid of pregnancy. Salt-water fish should be eaten if possible; and some form of iodine, such as the co-iodine tablets, administered.

The third mineral, *calcium,* is probably the one most required during pregnancy. Normally, about 10 mg. is present in 100 cc. of blood serum. This probably possesses only about 2 mg. of ionized, available, calcium; the rest is combined. Dr. Mull, in our laboratory, has shown that the calcium curve during pregnancy drops slightly through the winter months, and also shows another tendency to fall during the latter months of gestation. Plenty of calcium can be fed to the patient; the trouble is that it is not absorbed. Even after absorption, vitamin D must be present if the tissue is to utilize it. In the latter months of pregnancy, a woman needs 1.8 G. of calcium per day; and in the month before labor, the fetus requires 8 G. of calcium. There is a reservoir of more than 1 Kg. in the mother's bones and teeth, and this is drawn upon if the diet is deficient in calcium. Dr. Mull is now trying out a theory that, by feeding kaolin, the intestinal flora may be kept constant, so that the absorption of calcium will be more uniform. He will, himself, report his results when they are more complete.

So we should feed plenty of milk, cheese, and butter, with a cod-liver or halibut oil, to get plenty of the vitamin D. The direct administration of usable calcium is not so easy. Calcium chloride is irritating to the stomach. Calcium gluconate becomes the chloride in the stomach. However, when 10 cc. of 10 per cent calcium gluconate is injected intra-muscularly once or twice during pregnancy, remarkable improvement has been noted in cases of salivation, leg cramps, chorea, edema, and dermatitis.

CONCLUSIONS

1. The eclamptic and nephritic types of toxemia may be due to the fact that liver tissue is injured by syncytial products. So excessive amount of hormones are not removed by the liver, and these hormones cause the toxic symptoms.

2. Probably about 40 per cent of toxemic patients have some nephritis in later life.

3. In our series, 16 per cent of the babies died; and 30 per cent of the symptoms had appeared before the eighth month.

4. Fifty per cent of our patients show some nephritis today.

5. The uterus should be emptied if the symptoms start early, or are severe.

6. Hypertonic glucose, intravenous, is valuable.

7. Lack of iron, iodine, and especially calcium, is responsible for many of the other so-called "toxemias" of later pregnancy.

10515 Carnegie Ave.

— OSMJ —

Building Projects at 10 State Welfare Institutions to Start Soon

Work will be started in the near future on building projects at 10 state welfare institutions, to cost in the neighborhood of $1,200,000 and to provide additional facilities for the care of inmates suffering from tuberculosis and others in need of institutional care. The Federal Public Works Administration will finance 30 per cent of the cost and the state the balance.

The individual projects, their cost and the number of additional inmates which can be accommodated follow:

Cleveland State Hospital, new cottage, $145,000, 150 inmates.

Columbus State Hospital, new cottage, $118,750, 145 inmates.

Toledo State Hospital, two new cottage wings, $95,000, 100 inmates.

Longview State Hospital, completion of men's cottage and new women's cottage, $104,500, 100 inmates.

Apple Creek Institution for the Feeble Minded, new cottage, $237,500, 250 inmates.

Longview State Hospital, new cottage, $142,500, 150 inmates.

Dayton State Hospital, new cottage, $76,000, 80 inmates.

Athens State Hospital, two wings to existing cottages, $85,500, 90 inmates.

Girls' Industrial School, Delaware, new cottage, $95,000, 100 inmates.

Dayton State Hospital, new roofs for existing cottages, $47,500.

RETARDATION OF INCIPIENT SENILE CATARACT

By JOHN W. WRIGHT, M.D.,

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IT IS regarded by the profession generally that there can be no scientific or practical treatment in the clearing of a cataractous lens, nor can this be refuted where there is complete and time extended existence of such condition; otherwise, it is in the incipiency of senile opacity of the crystalline lens, as in the inception of many other organic affections, that a reasonable assurance of retardation or improvement may be placed. An opacity of the lens, as many other organic affections, does not develop without a cause. It cannot be attributed to age alone, as many nonagenarians have clear lenses.

The gradual sclerosing of the crystalline lens as age advances is in keeping with the decrease of the nutritive activities of all other organic structures, when, from its enfeebled condition, its capacity is doubtless the result of a systemic condition from an obstruction or infection of a remote organ. No organism in the entire system stands alone, but is often intimately associated with others, near or remote, in their functional activities. In perfect health all organs are supposed to function normally.

It is now generally regarded that the primary foci of a systemic affection usually originates in the exposed cavities of the mouth and nose, especially in defective teeth and infected nostrils, the toxins being carried to all parts of the alimentary canal, as the tonsils, stomach, gallbladder, colon, prostate and rectum, thence by the blood and lymph to all parts of the body, attacking chiefly, structures of diminished resistance. Doubtless, many affections of the adult have their origin in early life from the prevailing affections of childhood, which have been temporarily allayed by treatment, but in later life, when nutrition is diminished, obstinate systemic affections are incited. It is now known that many such affections are traced to diseased foci in very remote locations, the primary origin of which was an infection of the mouth or nostrils.

The management of focal infections is being placed on a more logical basis, which is contributing in a remarkable degree to the effective treatment of many hitherto obstinate diseases. Affections of the eye have partaken in this activity to a remarkable extent. While one remote affection causes irreparable blindness, another, as an uncomplicated senile cataract, is restorative to a considerable extent. Too much the eye has been regarded as an organ quite of itself, with little significance of other remote organs. It is now known that many serious affections of the eye have been permanently relieved by the extraction of an infected tooth or removal of an infected tonsil.

The crystalline lens, as other organic structures, must have nourishment, or it will become opaque. Nutritional disturbance of the lens may result from a variety of causes, which should be sought out if possible, and removed. After the fortieth year of life, affections leading to nutritional disturbances are more frequent and serious in character, and the very delicate structure of the crystalline lens makes it an object of attack, as indicated in the necessity of glasses for near work, through sclerosis of the lens.

Doubtless uncomplicated incipient opacity of the crystalline lens is as receptive to effective treatment as are many other organic affections. Rare cases of incipient senile cataract have been reported as having cleared in the absence of any treatment whatever. Such may have occurred spontaneously, or under a treatment of an affection regardless of the eye. In the author's service many cases have been retarded, and others completely cured under efficient systemic treatment. The primary object should be in the early recognition of the affection and its probable cause, that effective treatment may be undertaken under the most favorable circumstances, as the farther advanced is the opacity, the more obstinate and unavailing the treatment.

Inasmuch as imperfect functioning of the crystalline lens may result indiscriminately from defective conditions of various remote organs which affect general nutrition, no specific line of treatment is adaptable, but depends upon the origin and character of the offending affection. We should not treat the primary affection solely, but in addition other organs that may have become affected, as secondary complications are as effective in nutritive obstruction, as are the primary.

As the profession becomes more enlightened in the cause of many organic affections, more attention will be accorded the fact that there is an impelling effort within every living organism to rid itself of any affection that may have invaded its structures, which in the incipiency of senile cataract may be essentially facilitated through the efforts of a competent diagnostician in ascertaining the cause. It is here particularly in diagnostic uncertainty, that special consultants are requisite in directing the patient's physician in a rational treatment.

Inasmuch as many theories are conjectural and of doubtful intrinsic value, practical experience, enhanced by outstanding factors, must be relied upon. Hygienic measures, especially food economics, as secretion, digestion and assimilation, are important factors, and much may be accom-

plished in maintaining for a time at least, if not permanently, a trustworthy vision in the patient's accustomed occupation. It is here that the educated home physician who has constant surveillance of his patient, frequently achieves success.

As uncomplicated senile cataract is usually painless and progressive, many patients do not usually seek consultation until the vision is practically lost in one eye and materially defective in the other. As it is impossible in many cases, under the best directed treatment, to clear a partial opacity of the crystalline lens, it is fortunate in retarding its progress, especially while the patient has sufficient vision to accomplish his customary duties in safety.

1686 Summit St.

THE FREQUENCY OF CANCER OF THE FEMALE ORGANS

By F. E. DEEDS, M.D.,

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IT is the desire of the writer to point out by this paper, the number of deaths from cancer of the female organs, and to point a way the medical profession, with the cooperation of the laity, can reduce the number.

Much stress has been placed upon a yearly examination of laymen with comparatively few responding. In some places even these applicants have been discouraged by the profession, who either did not wish to bother, or do not know how to make such an examination. The laity as a whole do not know the value of such an examination and rebel at paying a sufficient fee and the physicians do not care to do the work for nothing, therefore much has been overlooked. I know of one business man that purposely took out an insurance policy once a year for the sake of the examination.

In the prevention of death from cancer of the female organs, the existing causes must be recognized and corrected, such as lacerations from child birth, and ulcers of the cervix. These, when found, should be treated and cured either by treatments or operation. The recognition of these and heeding them will do much to reduce the mortality.

As most of these cancers occur, as will be shown in the following tables, after the age of 40, a woman should have an examination yearly, beginning not later than this age. This should consist of a complete examination, and not merely an inspection. The use of the vaginal and rectal speculum is of considerable value and is often neglected.

According to Dr. D. Tod Gilliam, child bearing shows a large factor in the cause of cancer of the cervix. He observed that it occurred more frequently in women who had borne four or five children. Thus the prolific, healthy women were more prone than the non-para. His experience shows it occurred most frequently between the ages of 35 to 50. He also observed that the Caucasian race was more prone and that the negress was practically immune.

Dr. W. P. Graves states that in 538 cases of cancer of the cervix, 50 had never given birth to a child or had an abortion, thus 91 per cent were in women who had been pregnant. Ulcerations were present in 30 per cent and the average age in his group was 43 years.

He summarized these cases as follows:

Cancer of the cervix	538
Nulliparous	50

Of the last number he found the following:

Over 50 years of age	19
Between 40 and 50 years	11
Under 40 years of age	20
Past menopause (natural or artificial)	30
Never married	25
Obstructive lesions and ulcers (recorded)	16

In the past five years, in the State of Ohio we find the following deaths from cancer of the female organs:

Age	1928	1929	1930	1931	1932	Total
10-14	1	1	....	2	1	5
15-19	5	2	2	1	1	11
20-24	3	7	4	3	1	18
25-29	16	9	18	9	12	64
30-34	32	36	37	24	26	155
35-39	71	53	48	60	55	287
40-44	113	79	98	94	112	496
45-49	120	111	125	126	128	610
50-54	145	122	141	145	168	721
55-59	125	134	127	129	151	666
60-64	112	108	117	111	133	581
65-69	103	103	87	100	101	494
70-74	94	90	73	84	87	428
75-79	59	44	58	59	42	262
80-84	27	22	29	18	24	120
85-over	5	15	16	17	16	69
Total	1031	936	980	982	1058	4987

Thus with a total of 4987 in five years we find that the death rate has increased slightly, the average being 997.4. In glancing over this chart we find the greatest number occurred between the ages of 50-54. Of this number how many could

have been saved is a matter of supposition, but we do know that there would be some.

In the State of New York over the same period of time we find the following:

Age	1928	1929	1930	1931	1932	Total	Rate per 100,000 F. Population
Under 25	12	7	6	8	6	39	.7
25-34	26	51	38	41	34	190	8.8
35-44	137	141	120	130	140	668	31.7
45-54	232	244	255	251	240	1,222	73.6
55-64	257	288	254	269	317	1,385	116.1
65-74	200	207	213	219	256	1,095	149.0
75-over	96	90	103	92	98	479	145.5
Not stated	—	1	—	—	—	1	
Total	960	1029	989	1010	1091	5,079	35.9

In this group we find that the largest number occurred between the ages of 55 to 64, a period later than in the previous group. With the comparison of the population of the two states, New York with 12,588,066 and Ohio with 6,646,697, the rate in Ohio is far higher, there having been only 92 more in New York with a population of more than twice the number. Either they are more fortunate, or are doing more to prevent the development of the disease.

For comparison I am going to give the specified cause of death from cancer among females by age groups in registration states of 1920, including the District of Columbia, for the years 1930 and 1931 taken from the U. S. Census Bureau:

Age	Cancer of Uterus		Cancer of Ovary and Fall. tube		Cancer of Vagina and Vulva		Cancer of Other Female Gen. Organs	
	1931	1930	1931	1930	1931	1930	1931	1930
Under 5	1	2	—	4	1	—	—	—
5-14	2	5	15	11	—	1	1	1
15-19	6	12	21	15	3	1	1	2
20-24	61	51	24	20	4	3	1	1
25-29	161	206	36	41	3	2	—	1
30-34	61	51	24	20	4	3	1	1
35-39	817	763	126	99	15	12	1	1
40-44	1294	1282	191	191	18	24	4	3
45-49	1593	1529	267	236	27	25	5	7
50-54	1728	1693	295	241	38	28	4	3
55-59	1575	1670	259	243	46	39	—	5
60-64	1524	1449	220	214	44	48	2	7
65-69	1290	1186	196	165	67	66	5	6
70-74	995	959	116	97	58	48	6	2
75-79	628	529	44	46	51	38	1	—
80-84	308	297	24	22	24	17	—	2
85-89	132	135	6	8	14	12	—	1
90-over	30	29	4	2	5	5	—	—
All ages including unknown	12,593	12,295	1,905	1,703	431	372	32	45

Thus we again find that the mortality runs the highest between the ages of 50-54 years. This facing the profession, we can easily see that we must recognize these cases before that age is reached and by correcting it we can reduce these figures. The sharp rise coming at 40 years of age shows that we must do something before this age to obtain the best results.

The life insurance companies have been of real value in creating the desire of the laity to secure these examinations. They have advertised it in the press and by circulars, and are bringing these people to the profession. The one thing that has been neglected and seems to be the stumbling block for both the laity and the profession has been the value of such services. The profession as a whole is willing to do the examination, if properly compensated, and the laity is willing to stand its share, if properly instructed. When these examinations are undertaken it requires some time and the physician cannot see as many as he would in average office calls. If by some means this can be brought to the people it will aid them and also increase the doctors' practice.

To outline a chart and describe the various phases and conditions that should be observed would take another paper and can be found in text books and other sources. To be sure there are other conditions that should be looked for and cancer does not attack only the female organs. However cancer of these organs leads the list of causes of death in the female as is shown in the following table taken from Sajous:

	Male
Stomach	430.6
Liver	145.6
Head, Face and Neck	104.2
Mouth, Tongue and Neck	95.5
Lower Body	92.4
Rectum	54.9

	Female
Uterus	276.2
Stomach	244.7
Breast	157.8
Liver	125.9
Lower Body	76.9
Rectum	35.5

Thus we find that in the male the cancer is largely found in the stomach, in the female it occurs in greatest number in the female organs and the number in these cases makes it surpass the number in the men as a whole.

Bearing in mind the advancement of the medical science, a larger number of these cases, that a few years ago would have been considered hopeless, can now be saved. A few years back, unless the growth was confined to the organ and this removed in toto, great risk was involved. Before the advent of radium if the walls of the vagina were involved, the case was considered very grave and if it involved the bladder or the glands, it was hopeless. Now even these cases may be met and by the use of radium and sometimes the knife they can be saved. The ones that are hopeless are the ones where the metastases has occurred in other organs, which sometimes happens without the knowledge of the patient. A great number have been found and saved but our statistics do not show much of a decrease.

509 COLUMBUS AVENUE.

HIGH SPOTS OF PROGRAM AND ENTERTAINMENT FEATURES OF EIGHTY-EIGHTH ANNUAL MEETING, OHIO STATE MEDICAL ASSOCIATION, THURSDAY, FRIDAY AND SATURDAY, OCTOBER 4, 5 AND 6, COLUMBUS, OHIO

WEDNESDAY, OCTOBER 3

Medical and surgical clinics at various Columbus hospitals by members of the Columbus Academy of Medicine.

Annual tournament of the Ohio State Medical Golfers' Association, Columbus Country Club.

THURSDAY, OCTOBER 4

Opening Session of Annual Meeting and first meeting of the House of Delegates, 9 a. m. Junior Ballroom, northeast corner Mezzanine Floor, Neil House.

Second General Session, 11 a. m., Main Ballroom, northwest corner Mezzanine Floor, Neil House; address, Dr. R. T. Woodyatt, Chicago.

First Sessions of six Scientific Sections, 2:15 p. m., Neil House.

Third General Session, 8 p. m., Main Ballroom, Neil House; annual addresses of President and President-elect, Dr. C. L. Cummer, Cleveland, and Dr. John A. Caldwell, Cincinnati; address, Dr. Charles P. Emerson, Indiana University; informal reception in honor of officers.

Medical and surgical clinics at Columbus hospitals, 8 a. m. to 10 a. m.

FRIDAY, OCTOBER 5

Fourth General Session, 9 a. m., Main Ballroom, Neil House; addresses by Dr. Mont R. Reid, Cincinnati, and Dr. Clayton C. Perry, Cleveland.

Fifth General Session, 10 a. m., Main Ballroom, Neil House; program on "Progress in Tuberculosis", by Dr. C. A. Doan, Dr. B. K. Wiseman, and Dr. George M. Curtis, members of faculty, College of Medicine, Ohio State University.

Organization Luncheon for officers and legislative and medical defense committeemen of component county medical societies and academies of medicine; state officers and district councilors; members of standing and special committees of the State Association; members of the House of Delegates, and officers of the scientific sections, 12 noon, Neil House.

Sixth General Session, 2:15 p. m., Main Ballroom, Neil House; clinic on chronic arthritis, Dr. Russell L. Cecil, New York City.

Seventh General Session consisting of second and final session of House of Delegates, 3:30 p. m., Junior Ballroom, Neil House.

Eighth General Session, Annual Banquet under the direction of the Entertainment Committee, Columbus Academy of Medicine, Main Ballroom, Neil House; address, Dr. Gus W. Dyer, professor of political science, Vanderbilt University, Nashville, Tenn.

SATURDAY, OCTOBER 6

Ninth General Session, 9 a. m., Main Ballroom, Neil House; Motion Pictures.

Second and Final Sessions of six Scientific Sections, 10 a. m., Neil House.

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Registration Headquarters, Mezzanine Floor, Neil House.

Commercial Exhibits, Mezzanine Floor, Neil House.

Scientific Exhibits, Mezzanine Floor, Neil House, Blue and Pine Rooms, end of West Corridor.

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Admission to all sessions will be by badge only, obtainable at Registration Headquarters upon presentation of 1934 membership card.

Last Reminder Regarding Hotel Reservations at Columbus

Following is a list of Columbus hotels, their rates and conveniences from which those contemplating attending the Annual Meeting of the State Association, Thursday, Friday and Saturday, October 4, 5 and 6, can make their selection. Requests for reservations should be sent direct to the management of the hotel selected and verification of the reservation should be requested.

NEIL HOUSE

Headquarters Hotel

High Street Opposite State Capitol

655 rooms, all with bath; single room, $2.50 to $5.00; double room, $4.50 to $7.00; double room, twin beds, $5.00 to $7.00; suites, $7.00 up.

DESHLER-WALLICK

Broad and High Streets

1000 rooms, with bath; single room, $2.50 to $7.00; double room, $5.00 to $12.00; double room, twin beds, $6.00 to $12.00; suites, $10.00 to $25.00.

FORT HAYES

33 West Spring Street

300 rooms, with bath; single room, $2.00 to $3.00; double room, $3.50 to $5.00.

CHITTENDEN

Spring and High Streets

275 rooms; single room, with bath, $1.75 to $3.00; single room, without bath, $1.50 to $1.75; double room, with bath, $3.00 to $4.00; double room, without bath, $2.25 to $3.00; double room, twin beds and bath, $4.50 to $5.00; double room, twin beds but without bath, $3.50.

SOUTHERN

Main and High Streets

230 rooms; single room, with bath, $2.00 to $3.00; single room, without bath, $1.50 to $2.00; charge of $1.00 for each extra person and $1.00 additional for rooms with twin beds.

NEW VIRGINIA

Third and Gay Streets

130 rooms; single room, with bath, $1.50 to $2.50; double room, with bath, $2.50 to $3.50; single room, without bath, $1.25 to $1.50; double room, without bath, $2.00 to $2.50.

COLUMBUS

Long and Fifth Streets

200 rooms; single room, with bath, $1.50; double room, with bath, $2.50; single room, without bath, $1.00; double room, without bath, $1.75.

JEFFERSON

17 East Spring Street

80 rooms; single room, with bath, $1.75 to $2.25; single room, without bath, $1.25 to $1.50; double room, with bath, $3.00 to $4.00; double room, without bath, $2.50 to $3.00; suites, $5.00.

Tickets for Banquet and Dance Should be Obtained Early

Sale of tickets for the informal Annual Dinner, one of the entertainment features of the 88th Annual Meeting, will be conducted by the Entertainment Committee of the Columbus Academy of Medicine as soon as the meeting gets under way and up to mid-afternoon on Friday, October 5, the day of the banquet.

The dinner will start promptly at 6:30 p. m. and will be followed by an address by Dr. Gus W. Dyer, professor of political science, Vanderbilt University, a musical program, dancing and other forms of entertainment.

Dr. Russell G. Means, chairman of the Entertainment Committee of the Columbus Academy of Medicine, is especially anxious that all planning to attend the dinner purchase their tickets as early as possible so that the Neil House management can estimate as soon as possible the number of guests expected.

A desk at which banquet tickets may be obtained will be located near the Registration Headquarters to facilitate the sale of the tickets.

Members of the Entertainment Committee, in addition to Dr. Means, are: Dr. Link Murphy, Dr. Wells Teachnor, Jr., Dr. E. J. Stedem, Dr. J. N. Jentgen, Dr. Walter Hamilton, Dr. Audrey B. Atkinson, Dr. Ruth Koons Pereny, and Dr. Grace Welch.

Group reservations for the banquet will be handled by Dr. Means.

—OSMJ—

Vanderbilt Alumni Reunion

Alumni of the Vanderbilt University School of Medicine in attendance at the Annual Meeting of the Ohio State Medical Association will hold a luncheon reunion at the Neil House, Thursday noon, October 4. It is anticipated that somewhere between 40 and 50 will attend the reunion. Arrangements also have been made for a special table for Vanderbilt alumni at the Annual Dinner on Friday evening, October 5, when the principal speaker will be Dr. Gus W. Dyer, professor of political science, Vanderbilt University. Local arrangements for the Vanderbilt reunion are being handled by Dr. George M. Curtis, Ohio State University, formerly professor of anatomy at Vanderbilt University.

Interesting Scientific Exhibit Is Assembled for Annual Meeting

A Scientific Exhibit of unusual interest has been arranged for the 88th Annual Meeting of the State Association.

The exhibit will occupy the Blue and Pine Rooms on the Mezzanine Floor of the Neil House and will be open during the meeting.

The details of arranging for the scientific exhibits have been handled by the Scientific Exhibit Committee of the Columbus Academy of Medicine, consisting of Dr. G. I. Nelson, chairman, Dr. P. J. Reel, Dr. H. L. Reinhart, Dr. H. S. Fidler, Dr. R. W. Hoffman, Dr. E. G. Horton, and Dr. E. J. Gordon.

Up to the time *The Journal* went to press the following exhibits had been scheduled for presentation:

1. Bilateral Hare Lip Repair, Dr. D. M. Glover, St. Luke's, Lakeside, and City hospitals, Cleveland.

2. Allergy, Dr. Milton B. Cohen, Cleveland.

3. Indications and Methods for Surgery of Periocardium, illustrated with motion pictures. Dr. Claude S. Beck, Lakeside Hospital, Cleveland.

4. Encephalography, Dr. H. D. Piercy, Cleveland.

5. *X*-ray Exhibits of Pulmonary Lesions, Dr. Frank C. Anderson, Ohio State Sanatorium, Mt. Vernon.

6. Asymmetry of Nares and Dislocation of Lower End of Septal Cartilage in the Newborn and in Young Children, Dr. Myron Metzenbaum, Cleveland.

7. Diagnosis and Management of Urinary Calculi, Dr. C. C. Higgins, Cleveland.

8. Gall Bladder and Common Duct Diseases, Dr. Fred M. Douglass, Toledo.

9. Allergy, Dr. Jonathan Forman and Dr. John Mitchell, Columbus.

10. Public Health Services, State Department of Health, Columbus.

—OSMJ—

Luncheon for Women Physicians

Arrangements for the entertainment of women physicians in attendance at the 88th Annual Meeting, Columbus, October 4, 5 and 6, are being completed by the Women's Entertainment Committee of the Columbus Academy of Medicine, composed of Dr. Edith Offerman, chairman, Dr. Grace Welch, Dr. Grace Jordan, Dr. Isabel Bradley, Dr. Emilie Gorrell and Dr. Charlotte Winnemore.

One of the principal events so far scheduled is a luncheon for all medical women at the Neil House Friday noon, October 5.

Explanation of Fees for Minor Injuries in F.E.R.A. Cases

According to D. F. McMurchy, director of the Department of Safety, State Relief Commission, in charge of all details in connection with the payment of fees for medical services to F.E.R.A. Works Projects employes disabled while at work, some confusion has arisen relative to the fees allowed physicians attending such cases.

As emphasized in *The Ohio State Medical Journal*, page 389, June, 1934, issue, the regulations pertaining to Works Projects accident and disability cases state that the fees to physicians for treating *minor injuries* (those which do not involve surgery, orthopedics, or anesthesia) shall be the same as those found in the medical fee schedule contained in Supplement No. 1 (Revised) to Rules and Regulations No. 7 of the F.E.R.A. governing medical care in the home to recipients of unemployment relief.

Therefore, physicians attending Works Projects employes for *minor injuries* should charge $1.00 for an office call and $2.00 for a house call, plus 50 cents if between 9 p. m. and 7 a. m. and plus the regular mileage allowance specified in the fee schedule under Supplement No. 1 (Revised) to Rules and Regulations No. 7. (See April issue of *The Journal*).

In handling cases which do not come under the classification of "minor injuries", the attending physician may submit a bill based on the current fees allowed by the State Industrial Commission which are 20 per cent less than those appearing in the printed General and Special Fee Schedule of the Commission.

Some physicians in submitting their bills, according to Mr. McMurchy, have been charging for the treatment of minor injuries at the rates paid by the State Industrial Commission which has led to confusion and delay in the payment of medical bills for services to injured F.E.R.A. employes.

—OSMJ—

100 Year Book Off the Press

Announcement has been made that the One Hundred Year Book of the College of Medicine, Ohio State University, is now off the press. Those who have subscribed for the book may, if they desire, obtain copies during the Annual Meeting of the Ohio State Medical Association in Columbus, October 4, 5 and 6, by getting in touch with A. J. Linn, secretary to the Dean, College of Medicine, Ohio State University, who, also, will take subscriptions for volumes. The book contains narrative data on the growth and development of the medical college, with biographical notes on the faculty and pictures of the various graduating classes.

IMPRESSIVE PROGRAM OF HOSPITAL CLINICS PRELIMINARY TO ANNUAL MEETING TO BE PRESENTED BY COLUMBUS PHYSICIANS

One of the most instructive, varied and extensive programs of medical and surgical clinics ever arranged as a preliminary feature for an Annual Meeting of the Ohio State Medical Association has been announced by Dr. Fred Fletcher, chairman of the Clinic Committee of the Columbus Academy of Medicine, for the 88th Annual Meeting in Columbus.

The clinics will be held at Columbus hospitals Wednesday morning and afternoon, October 3, and from 8 to 10 a. m. on Thursday, October 4, the first day of the Annual Meeting.

Those who assisted in formulating the clinic program, which follows, were: Dr. W. P. Smith, Dr. Earl H. Baxter, Dr. I. B. Harris, Dr. Joseph Price, Dr. Andre Crotti, Dr. Charles E. Turner, and Dr. Charles A. Doan:

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CHILDRENS HOSPITAL

561 South 17th Street

WEDNESDAY, OCTOBER 3

The hospital dispensary and wards will be open for inspection during the day. The medical dispensary will open at 8:30 a. m. and the orthopedic dispensary at 11 a. m.

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

1. Case Presentation, DR. O. L. BALDWIN.
2. The Relation of Orthodontic Defects to Child Health, DR. C. A. ALDRICH.
3. Acrodynia, DR. E. H. BAXTER.
4. Fractures in Children, DR. E. H. WILSON.
5. Encephalitis, DR. JOHN E. BROWN, JR.
6. Primary Carcinoma of Liver, DR. J. E. BRIGGS.

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GRANT HOSPITAL

State Street and Grant Avenue

WEDNESDAY, OCTOBER 3

8 a. m.

DR. ANDRE CROTTI

1. Thyroidectomy
2. Thyroidectomy
3. Thyroidectomy
4. Hysterectomy
5. Hysterectomy.

10 a. m.

DR. J. F. BALDWIN
(Work to be announced later)

DR. HUGH A. BALDWIN
Supra-pubic Prostatectomy

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

DR. A. M. STEINFELD and DR. H. P. WORSTELL

1. Bilateral Reduction of Congenital Hips.
2. Multiple Fractures of Elbow Joint and Ulna with Nerve Involvement.
3. Open Reduction of Oblique Fracture of Humerus.
4. Osteochrondromatosis of Elbow Joint.

DR. I. B. HARRIS
Dry Clinic.
Pyloric Resections.

9 a. m.

DR. FRANK W. HARRAH
Canalized Shadowless Ureteral Stones; Illustrated with Films.

DR. S. J. GOODMAN
Caesarean Section (Previous Caesarean Section on account of Eclampsia).

10 a. m.

DR. J. F. BALDWIN
(Work to be announced later).

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MERCY HOSPITAL

1430 South High Street

WEDNESDAY, OCTOBER 3

9 a. m.

DR. JOSEPH PRICE, DR. JOHN WENZKE and ASSOCIATES.

1. Cholecystectomy. Spinal.
2. Hernioplasties. (2) Spinal.
3. Hysterectomies. (2) Spinal.
4. Cystocele. Vaginal Plastic.
5. Varicose Veins—injection treatment.
6. Series of Interesting Fracture Cases.

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

DR. JOSEPH PRICE, DR. JOHN WENZKE and ASSOCIATES.

1. Thyroidectomy.
2. Hysterectomy. Spinal.

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MT. CARMEL HOSPITAL

793 West State Street

WEDNESDAY, OCTOBER 3

8 a. m.

DR. GEORGE P. SIMS
Radiation Therapy Clinic

1. Osteosarcoma of Illium.
2. Acute Infectious Cellulitis.

3. Breast Malignancy.
4. Malignant Papillary Cystadenoma of Ovary.
5. Hyperthyroidism.

DR. H. F. FULTON
Presentation of Series of Diagnostic X-ray Films.

DR. C. E. TURNER AND ASSOCIATES
1. Value of Ascheim-Zondex Test in Pregnancy.
2. Tentative Obstetrical Case.

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

Surgical Department Clinics
DR. C. S. HAMILTON, Surgery.
DR. WELLS TEACHNOR, JR., Surgery.
DR. H. H. YOAKEM, Surgery.
DR. WELLS TEACHNOR, SR., Rectal clinic.
DR. E. J. STEDEM, Hysterectomy.
DR. ANDRE CROTTI, Thyroidectomy (2); Hysterectomy.
DR. H. O. BRATTON, Resectoscopic.
DR. E. W. TROUTMAN, Tonsillectomy; local.

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ST. FRANCIS HOSPITAL

311 East State Street

WEDNESDAY, OCTOBER 3

8 a. m.

DR. RUSSELL G. MEANS
Tonsillectomies (5); Demonstration of Various Techniques.

8 a. m. to 10 a. m.

DRS. VAN BUSKIRK, SHERBURNE, RARDIN AND GOLDSTEIN
Ward Walks.

2 p. m.

DR. I. B. HARRIS
1. Thyroidectomy.
2. Cholecystectomy.
3. Prostatectomy.

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

DR. LUKE ZARTMAN
Surgical Clinic

DRS. VAN BUSKIRK, SHERBURNE, RARDIN AND GOLDSTEIN
Ward Walks.

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UNIVERSITY HOSPITAL

Neil Avenue at University Campus

WEDNESDAY, OCTOBER 3

9 a. m.

DR. VERNE A. DODD AND STAFF
Operative Clinic in General Surgery

DR. JOHN W. MEANS
Diagnostic Clinic.
Transillumination of the Breast with Cutler's Lamp; A-120. First Floor.

DR. JACK TAYLOR
Operative Clinic-Urology.

DR. HUGH G. BEATTY AND DR. E. W. HARRIS
Bronchoscopic Clinic.

10 a. m.

DR. GEORGE M. CURTIS
Total Thyroidectomy for Heart Disease. B-1.

DR. PAUL CHARLTON
Blood Transfusion in Septic States. Surgical Ward.

DR. S. D. EDELMAN
Bacterial Endocarditis in Childhood.

DR. MARY GRABER
The Problem of Infant Nutrition.

DR. E. G. HORTON
Hirschsprung's Disease.

DR. E. H. BAXTER
Continuous Intravenous Infusion.

DR. ANDREWS ROGERS
1. Problems Involved in the Handling of Preeclamptic Patients.
2. Operative Delivery in Obstetrics.

DR. G. I. NELSON
Medical Management of the Diabetic Patient. Medical Wards.

DR. PHILIP KNIESS
Fluroscopic Clinic. X-ray Department.

DR. FRANK WAGENHALS
Trauma as a Causative Factor in Paralysis Agitans. Medical Wards.

DR. JOHN E. BROWN, JR.
Intravenous Therapy in Infancy. Demonstration.

DR. VERSA COLE
Iodine Balance as Related to Thyroid Function.

DR. C. A. DOAN AND DR. HARGRAVES
Superavital Technic for Studying Living Blood and Tissue Cells. Room 208.

PROF. F. A. HARTMAN
The Adrenal Gland and the Extraction of Cortin. Room 2.

11 a. m.

DRS. CURTIS AND PUPPEL
Osteogenesis Imperfecta and Calcium Balance. B-1.

2 p. m. to 4:30 p. m.

Gynecologic Clinic.

DR. FRED FLETCHER AND DR. PHILIP REEL
1. Ten Operative Cases.
2. Application of Radium.
3. Spinal Anaesthesia.

2 p. m. to 5 p. m.

DR. RUSSELL G. MEANS
Broncho-Sinusitis in Children, Operative Clinic and Demonstration of Operative Results.

DEMONSTRATION AT KINSMAN HALL LABORATORIES:

DRS. WISEMAN AND MOORE
Warburg Studies of Cell Respiration. Room 1.

PROFESSOR W. A. STARIN

The Dissociation of Tubercle Bacilli—Cataphoretic Studies. Room 1.

NORMAN MATHEWS

The Microdetermination of Iodine. Room 206.

THURSDAY, OCTOBER 4

8 a. m. to 10 a. m.

DR. A. D. FROST

Operative Eye Clinic.

DR. JACK TAYLOR

Operative Genito-Urinary Clinic.

DR. HARLAN WILSON

Fusion of Hip-Operative Clinic.

DR. S. A. HATFIELD

Coronary Vessel Disease. Medical Wards.

DR. E. G. GORDON

Gastric Ulcer. Medical Wards.

DRS. DOAN, HARGRAVES AND LOWENSTEIN

A Comparison of the Fever Machine and Malaria Treatment in Syphilis of the Central Nervous System. Research Service, B-1.

DR. B. K. WISEMAN

Differential Diagnosis and Therapy of Lymphadenopathies. Research Service, B-1.

DRS. DOAN AND CURTIS

Splenectomy in Acute Hemoclastic Crises. Research Service, B-1.

DRS. BARRON AND LOWENSTEIN

Amyloid Disease. Research Service, B-1.

DR. LOUIS BARRON

Intranasal Oxygen Therapy—Demonstration. Research Service, B-1.

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WHITE CROSS HOSPITAL

700 North Park Street

WEDNESDAY, OCTOBER 3

8 a. m.

DR. FRED FLETCHER

1. Cholyecystectomy.
2. Pan-hysterectomy. Myoma.
3. Hernioplasty. Babcock Technic.
4. Webster-Baldy Suspension. Perineorraphy.
5. Epithelioma of Cervix. Radium by DR. NED KIRKENDALL.

DR. WILLIAM P. SMITH

1. Salpingectomy.
2. Hysterectomy.

DR. CARL D. HOY

1. Fracture of Spine—open operation.
2. Cholecystectomy.
3. Salpingectomy.
4. Hysterectomy.
5. Appendectomy.
6. Lane Plate—Femur.

DR. E. C. LUDWIG

Discussion of Anaesthesia during Operative Clinics.

DR. W. F. MILLHON

Treatment of Septicemia.

8:30 a. m.

DR. R. W. KISSANE AND DR. R. S. FIDLER

1. Experimental Studies on Diet Induced Arterio-sclerosis in Albino Rats.
2. A Type of Anemia Associated with Mitral Stenosis.

9:30 a. m.

DR. NED KIRKENDALL

Roentgen Therapy in Skin Malignancies. Presentation of Patients.

10:30 a. m.

DR. H. V. WEIRAUK

Roentgen Diagnosis in:

1. Subphrenic Abscess.
2. Intestinal Obstruction.
3. Post-operative Massive Collapse of the Lungs.

11 a. m.

DR. FRANK WARNER

Swedish Method of Treatment of Fractures of the Neck of the Femur.

DR. W. D. INGLIS (Obstetrical Floor)

1. Treatment of the Toxemias of Pregnancy.
2. Roentgen Studies of the Pelvis in Pregnancy.

1 p. m.

DR. FRANK HARRAH

1. Nephrectomy.
2. Prostatectomy.

DR. E. H. CHAPIN

1. Hysterectomy.
2. Hernioplasty.

DR. C. S. PERRY

Fusion Exercises and Operative Management of Squints.

1:45 p. m.

DR. R. S. FIDLER

Newer Laboratory Methods in Differential Diagnosis of Anemias.

2:30 p. m.

DR. WYNNE SILBERNAGEL

Anatomical Defects of New-Born Other Than Monstrosities.

3:15 p. m.

DR. R. S. FIDLER

Consideration of the Anterior Pituitary Hormones.

4 p. m.

DR. JOHN HOBERG

Clinical and Roentgen Studies of Renal Calculi.

THURSDAY, OCTOBER 4

8 a. m to 10 a. m.

DR. FRED FLETCHER

1. Cholecystectomy.
2. Pan-hysterectomy. Myoma.

DR. WILLIAM P. SMITH

Interposition Operation for Uterine Prolapse.

8:30 a. m.
DR. LOUIS MARK
Non-tuberculous Lung Infections.

9 a. m.
DR. H. E. BOUCHER
Hysterectomy.

DR. CARL D. HOY
Diagnosis of the Acute Abdomen.

DR. W. E. MASTERS
Schuller-Christian Syndrome. Case Presentation.

Study Outline No. 4

Intestinal Obstruction (Ileus)

By CARL R. STEINKE, M.D.
AKRON, OHIO

OUTLINE FOR STUDY

1. DEFINITION:

2. CLASSIFICATION:
   - A. Acute. Partial or complete (usually the latter).
   - B. Chronic. Generally partial. May become complete.

3. SYMPTOMS:
   (Caused by interference with fecal current). Discuss reasons for variation in degree and severity.
   - A. Early:
     1. Pain.
        - a. Early is intermittent and colicky.
        - b. Later is constant.
        - c. Discuss pain in general and in differentiating various obstruction causes. Which has little or no pain?
        - d. In chronic condition pain may extend over period of days or weeks.
     2. Nausea?
     3. Vomiting (character of).
     4. Stoppage of stools.
        - a. Complete.
        - b. Alternating diarrhea and constipation.
     5. Distention.
        - a. Why variable?
        - b. Results of.
     6. Poor appetite.
     7. Toxic syndrome.
        - a. Pulse.
        - b. Blood pressure.
        - c. Prostration.
   - B. Late—(Should not be classed as symptoms but terminal result).
     1. Marked distention.
     2. Fecaloid vomitus.
     3. Rapid feeble pulse.
     4. Exhaustion.
     5. Muscular weakness.
     6. Anxious expression.
     7. Delirium.
     8. Coma.

4. CAUSES:
   - A. Mechanical (mechanical obstruction).
     1. External.
        - a. Tumors. Benign or malignant).
        - b. Peritonitis (acute or chronic).
        - c. Membranous bands (adhesions of various types and different locations. May kink or constrict bowel. Meckel's diverticulum. Diffuse adhesions from various causes).
        - d. Herniation with and without strangulation.
          (1) External (various types)
          (2) Internal (several varieties)
        - e. Volvulus.
        - f. Ulcerations with scar constriction.
          Luetic. Tuberculous. Pyogenic organisms.
          Amoebae. Gonococci.
     2. Internal.
        - a. Neoplasms filling lumen.
        - b. Intussusception.
        - c. Foreign bodies (swallowed material; enteroliths; gall stones; worms, ascarides especially).
   - B. Peristaltic obstruction.
     1. Dynamic ileus (spasticity).
        - a. Post operative.
        - b. Lead poisoning.
        - c. Functional in new-born (dynamic and adynamic).
        - d. Organic in new-born (stenosis; atresia; faulty rotation; annular pancreas; congenital tumors.
     2. Adynamic or paralytic ileus.
        - a. Toxic or infectious.
        - b. Peritonitis.
        - c. Pneumonia.
        - d. Circulatory.
        - e. Thrombosis or embolism.
        - f. Nervous.
        - g. Cardio-vascular.

h. Septic foci.
i. Trauma to abdomen.
j. Spinal cord lesions.

5. PATHOLOGY:
(In acute and chronic types different).
Changes in intestine from various causes outlined.
Changes in other organs.

6. PHYSICAL EXAMINATION:
A. Early—
1. Those signs caused by suffering, as facial expression.
2. Flexed thighs and legs.
3. Slight distention and may be local over obstructed area.
4. Visible peristalsis at times.
5. Audible peristalsis at times.
6. No result with enemata or flushings.
B. Later—
1. Dry tongue.
2. Changes anxious facial expression.
3. Marked distention.

7. LABORATORY FINDINGS:
A. Normal W.B.C. and R.B.C. (increased if dehydrated).
B. Reduced blood chlorides.
C. Increase in non-protein nitrogen (urea increase).
D. Urine scanty.

8. DIAGNOSIS:
History of hernia, previous operation, peritoneal inflammation or presence of abdominal tumor are important.
Differential diagnosis made from taking a good history correlated with the physical findings.

9. TREATMENT:—
Gastric lavage preceding operation?
A. Immediate operation.
1. Incision.
2. Loosen bands and adhesions.
3. Resection.
4. Anastomosis around obstructed area. Various methods.
5. When use enterostomy, cecostomy or colostomy?
6. Question of anesthesia.

10. POST-OPERATIVE TREATMENT:
A. Dressing.
B. Drugs.
C. Gastric lavage or duodenal drainage (Wangensteen).
D. Enemata; colonic flushings.
E. Intravenous or hypodermocylsis solutions.
F. Diet.

11. COMPLICATIONS:
A. Peritonitis.
B. Severe toxemia with its results.

12. SEQUELAE:
A. Adhesions.
B. Stricture.

13. PROGNOSIS.

14. CAUSE OF DEATH.
A. Human being pathology.
B. Experimental pathology and findings.

15. REVIEW EXPERIMENTAL WORK:

SUGGESTIONS FOR PAPERS

1. Acute intestinal obstruction.
2. Cause of intestinal obstruction and treatment of the various lesions.
3. Experiments on animals, with results of operations.

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The President's Page

A Personal Communication to the Membership from
C. L. CUMMER, M.D., *President*, Cleveland, Ohio

CIVIC AND POLITICAL OBLIGATIONS

Fellow member and brother physician, please read this letter as attentively as though it had come to you by first-class postage in a personally addressed envelope. It deals with matters which are of vital interest to you. Whether you are general practitioner, specialist, full-time teacher, or health worker makes no difference, you all appeal to this Association for aid when the best interests of public health, your professional privileges or economic interests, or the freedom of scientific research is threatened by inimical legislation. You must realize that physicians can no longer assume an attitude of indifference to public affairs. If you have not done so, you should read at once the articles in the August issue of this *Journal* entitled "Gigantic Government Expansion Through Social Insurance Object of Concerted Move by Political and Welfare Groups", and "What Will be the Status of the Medical Profession in the Changing Social Order?". Actions by the government and semi-official bodies point all too clearly to necessity for active participation in public life by you to protect both the best interests of yourself and your profession as well as those of people whom you serve.

As pointed out by the Policy Committee of the Ohio State Medical Association in the articles just referred to, the future form and character of our government may depend on the attitude of those elected to the next Federal Congress.

You may have felt that you personally need waste no time with such matters; that all would be taken care of by "the people in Columbus", or in Chicago, or some other remote place, absolving yourself from any effort and incidentally from any responsibility for the outcome. If so, let me tell you that you are wrong. The battle of today is your own; it is to be fought out not in the remote future, not next year, but next month; and the battleground will be the countless election booths of this state.

Numerous and varied proposals with medical bearing are certain to be introduced in the next session of the Legislature. Many will be of the sorts which have arisen to plague us in the past, attempts in one form and another to lower the qualifications of those desiring to practice the healing art. Others would doubtless lead to serious economic infringements. However, some of the most insidious and dangerous inroads in recent months have not come directly through legislative action but by bureaucratic rule, and so can be met only through approach to the administrative branch of the government.

Do you ask what you can do about all of this? The answer is in the intelligent use of your rights of citizenship, and is given categorically as follows:

1. Doubtless at least one or more of the candidates for public office are either patients or personal acquaintances of yours. Interview them immediately and tactfully ascertain their position in regard to medical affairs and present-day tendencies toward the socialization of medicine.

2. Warn them of the dangers of committing themselves by promises to any groups. Often excellent legislators, intelligent and willing to listen to reason, come to Columbus "hand-tied" by campaign pledges made thoughtlessly. Attempt to prevent this.

3. Inform your county medical society legislative committeeman fully of any contacts you have made and of the results.

4. Urge your legislative committeeman, who should be the leader in this campaign for your county, to give you complete information regarding all candidates well in advance of election day.

5. Guided by the information you secure from him, work among your friends to bring about the election of qualified and properly minded candidates.

6. Be careful to make no enemies for organized medicine by proclaimed opposition to candidates whose opinions differ from your own; work unobtrusively, but none the less actively.

These directions are entirely non-partisan. In both parties we have friends and enemies, radicals and conservatives. Some of the candidates have easily available records so that you can tell what you may expect from them. Those without records should be interviewed and reasoned with, and their mental qualifications carefully studied and reported.

You who are county legislative committeemen will find your work outlined for you. After you have compiled all information possible about candidates, please communicate it to your membership by personal interview or at the meetings of your society. Be careful about written or printed matter; discretion demands that only the favorable appear in this way. Keep your Columbus headquarters fully informed of your activities.

Within a short time the Annual Meeting of our Association will be held in Columbus. Our capital city is noted for its hospitality; it is easily accessible from all parts of the

state; the splendid scientific program furnishes a wonderful brief course of graduate instruction which you cannot afford to miss. This year it happens to be unusually well-timed, for it affords you an opportunity to learn of the ominous social and governmental developments of the past year. If you are a delegate, your paramount duty is to be present and participate in the policy-determining sessions of the House of Delegates. If you are not a delegate, be sure that your county is represented, and attend yourself also, for there is no conflict with the scientific sessions and you will go home far wiser. So we hope that you come to Columbus; but in any event, remember your duty as a medical man and a citizen. The situation is critical and the battle must be won on your home-soil.

Dr. Cummer Speaks at A.M.A. Meeting

Dr. C. L. Cummer, Cleveland, President of the Ohio State Medical Association, was one of the speakers at the Annual Conference of Secretaries of Constituent State Medical Associations, sponsored by the American Medical Association and held on September 21 and 22 at the Palmer House, Chicago.

Dr. Cummer discussed "The Educational Possibilities of Scientific Programs at State and County Meetings". Part of his address was devoted to an analysis of the "Study Outline" feature, of which he is a strong advocate, and how this may be developed. He distributed at the meeting reprints of several of the "Study Outlines" which have appeared in recent issues of the *Ohio State Medical Journal* for use by county medical society program committees.

— OSMJ —

Dr. Wilce Named Director

Reorganization of the medical and health service at Ohio State University was announced recently by President George W. Rightmire. The service will be known in the future as the University Health Service. The new director is Dr. John W. Wilce, former professor of physical education and an associate physician in the health service. Dr. Wilce will hold the rank of professor of medicine in the College of Medicine. Other members of the health service staff and their faculty rankings are: Dr. M. F. Osborn, associate professor; Dr. James A. Beer, Dr. Shirley Armstrong and Dr. Charlotte Winnemore, assistant professors, and Dr. J. M. Foley, instructor. It is planned to name a health council to serve in an advisory capacity.

— OSMJ —

The 1934 International Assembly of the Interstate Post Graduate Medical Association of North America will be held in the Public Auditorium, Philadelphia, November 5 to 9, inclusive, with pre-assembly clinics on November 3 and post-assembly clinics on November 10. A large number of distinguished teachers and clinicians will take part in the program, being arranged under the chairmanship of Dr. George W. Crile, Cleveland, also one of the essayists. Other Ohio physicians who will address the assembly are Dr. Russell L. Haden, Cleveland, Dr. William E. Lower, Cleveland, and Dr. Louis J. Karnosh, Cleveland.

Braught Quits as Relief Director

Major E. O. Braught, executive director of the State Relief Commission since the formation of the commission in 1931, has resigned to accept a position as a regional executive under the Federal Emergency Relief Administration with headquarters in Denver. He will have supervision over a number of western states. Up to the time *The Journal* went to press, his successor had not been selected by the State Relief Commission.

— OSMJ —

The Cook County Graduate School of Medicine, Chicago, will offer, starting October 22, a two weeks' intensive course in ear, nose and throat and a 10 days' intensive course in fractures and traumatic surgery, providing the required number of physicians register. The number permitted to take the work will be limited. The clinical work will be given at the Cook County Hospital and the didactic work at the school building.

— OSMJ —

Dr. F. C. Warnshuis, Grand Rapids, Michigan, for the past 21 years secretary of the Michigan State Medical Society, has resigned that position to become secretary-treasurer and director of public relations of the California Medical Association. sociation.

— OSMJ —

Miss Mary A. Jamieson, Columbus, former superintendent of Grant Hospital and a past president of the Ohio Hospital Association, has been appointed to a newly created position in the medical department, State Industrial Commission, known as hospital and home inspector.

— OSMJ —

Activities of sneak thieves in the dressing rooms of physicians in a number of hospitals in different parts of the state have been reported. One thief who pretended to be looking for a certain physician obtained approximately $100 from physicians' clothing in a dressing room at Providence Hospital, Sandusky, recently.

— OSMJ —

Miamisburg—Offices for general practice have been opened here by Dr. Roscious C. Doan, former intern and resident physician at the Miami Valley Hospital, Dayton.

ANNUAL REPORT OF THE COMMITTEE ON PUBLIC POLICY

C. W. Stone, Chairman, (1935).....Cleveland
J. H. J. Upham, (1934).....Columbus
John B. Alcorn, (1936).....Columbus
C. L. Cummer, (ex-officio).....Cleveland
John A. Caldwell, (ex-officio).....Cincinnati
Don K. Martin, Secretary.....Columbus

Since neither time nor space will permit a detailed report of the multiple activities of the Committee on Public Policy during the past year, we can do little more in this report than summarize briefly some of the principal questions the Committee has been called upon to consider and a few of its major activities.

However, in this recapitulation, the Committee attempts to present first-hand information acquired from intimate contact and actual experience with some of the important social, economic and governmental developments which have made this the most critical period in all history for the medical profession.

For the sake of brevity, frequent reference will be made to articles regarding the Committee's activities which have been published in *The Ohio State Medical Journal*, and these references should be considered as included in this report.

Certain basic policies and principles which have governed the work of the Committee will be reemphasized and certain dangers confronting the medical profession commented upon.

MEDICINE THE TARGET OF SOCIAL TINKERERS

After analyzing major events, developments and trends in our national life during the past year, the Committee is not surprised that medicine has been caught in the maelstrom produced by the titanic struggle between social, economic and governmental reformers and tinkerers on the one side and the proponents of sound social, economic and governmental principles on the other.

For years medicine has been the target of so-called advanced thinkers on social welfare questions. Powerful and influential forces headed up by the representatives of a number of philanthropic and research foundations and certain welfare organizations have been carrying on a campaign to establish an elaborate system of social medicine in this country.

Propaganda originating from the majority report of the Committee on the Costs of Medical Care and similar undertakings by those with preconceived ideas regarding medical and health questions has lent impetus to the movement to destroy the present system of medical service and erect in its place a new one, based on questionable social and economic theories as well as dangerous medical doctrines.

Now we find ourselves in the midst of a social revolution with reform as the keynote and action as the slogan but comparatively little consideration for fundamentals or the lessons taught by the experiences of history. This, coupled with the fact that the present national administration is definitely committed to a comprehensive system of governmental social insurance, including provision for medical care, has added further impetus to the drive for the complete socialization of medicine.

FUTURE STATUS OF MEDICINE IN DOUBT

As pointed out in a statement and pronouncement, "What Will Be the Status of the Medical Profession in the Changing Social Order", formulated by the Committee on Public Policy, approved by the Council of the State Association, and published in the August, 1934, issue of *The Journal*, pages 516 and 517, "the medical profession is being coerced and regimented under the new social order".

Moreover, as intimated in that pronouncement, unless the medical profession together with other organized groups who realize the dangerous tendencies exemplified by recent departures in our national life and principles of government, swing into action and attempt to halt exploitation of the public by the social experimenters, bureaucracy will be in the ascendency, enforcing regimentation and dictatorship over the American people.

Medicine being directly involved in this gigantic social experiment has a perfect right, in fact is obligated, to voice its frank opinions and take whatever direct action it deems advisable regarding any and all social programs which directly, or even remotely, affect the practice of medicine and incidentally the health of the public.

The attitude of organized medicine toward changes in the nature of medical practice are clear-cut and definite.

Organized medicine *is not* and never has been opposed to changes in the nature of medical practice which are basically sound and can be proven as practical.

Organized medicine *is not* and never has been opposed to properly controlled experience in providing medical service.

Organized medicine *is not* convinced that private medical practice, when ethically and efficiently conducted, has failed to meet social, economic and medical demands of a community, as some proponents of change would have the public believe.

Organized medicine *is* convinced that the stand-

ards of medical care in this country are higher than those to be found in any other country, regardless of the system of medical care under which it operates.

BASIC PRINCIPLES ENUMERATED

Organized medicine *stands for* certain basic principles in any form of medical practice which are fundamental to a maintenance of the high quality of medical care and certain inalienable rights of the individual physician.

These principles were, we believe, well summarized in the following decalogue set forth by the House of Delegates of the American Medical Association in Cleveland to guide medical practice and to form the basis for any experiment that may be contemplated:

1. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.
2. No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.
3. Patients must have absolute freedom to choose a duly qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.
4. The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.
5. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.
6. However the cost of medical service may be distributed, the immediate cost should be borne by the patient if able to pay at the time the service is rendered.
7. Medical service must have no connection with any cash benefits.
8. Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.
9. Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.
10. There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

The medical profession should observe and support these principles and demand that they be preserved in any form of medical practice contemplated or undertaken.

Your committee agrees with the sentiments expressed in an editorial published in *The Journal of the American Medical Association* (July 14, 1934), which said in part:

"On the principles adopted by the House of Delegates, the American medical profession must stand, and in their favor it must speak with a united voice. This is no time for the activities of the individual who seeks personal prestige and political preferment as a reward for contributed leadership. In most of the great nations of the world, social medicine has been the panacea proffered by politicians and philanthropists against social unrest. Let us learn from the experience of those who have tried and who, in many instances, have failed. Let us not be misled by high sounding phrases and insidious diction. Let us beware of generalizations which lead to disaster when the details of their fulfilment become apparent. Let us consider carefully, act with caution, reserve judgment, and speak with one voice for the truth."

We would add to this plea for harmonious and concerted thought and activity on the part of the profession an appeal to every physician to realize the importance of an active interest in civic and political matters.

As was emphasized in the statement of policy previously referred to (August, 1934, issue *The Journal*); "It may be predicted positively that the future trend, tendency and structure of government in this country will be determined by the next Congress". And, to quote again from that pronouncement: "In this crisis it is a patriotic duty to be politically-minded".

If the future of medical practice in this country is destined to be settled in the political arena —and it looks much that way at present—then it behooves the medical profession to use every influence at its command to have seated in public offices men of sound judgment and experience, cognizant of the qualifications of the representatives of organized medicine to speak for the profession regarding medical questions, and willing to judge on their own merits the principles and policies on which the profession has united.

PROBLEMS OF MEDICAL CARE TO INDIGENTS

To those who fail to see or are reluctant to admit the probabilities of innumerable difficulties and evils in any system of medical practice supervised by bureaucracy and controlled through virtual dictatorship, we cite the experience in our own state under the alleged "temporary and emergency" plan established in the Fall of 1933 to provide medical care for thousands of families on the relief rolls of the state.

The medical profession of Ohio is, of course, thoroughly familiar with the difficulties and complicated problems, as well as injustices, that have arisen under the medical plan established in Ohio under Rules and Regulations No. 7 of the Federal Emergency Relief Administration.

However, your Committee believes it timely and appropriate to summarize some of the high

points of the situation inasmuch as it furnishes an example of what can be expected if the practice of medicine and medical service become but an incidental part of a gigantic social welfare plan, supervised by political appointees, exposed to the inefficiency of bureaucracy, and the plaything of socially-minded brain-trusters.

It is well for us to frankly recognize that conditions were exceedingly serious when the vast relief machine of the government, national and state, took control of the enormous task of providing the necessities of life for thousands of victims of the economic collapse.

It was understandable that many traditional and normal relationships had to be suddenly modified or ignored in the hastily-formulated drive to meet an *emergency* that, in the frank opinion of some officials, verged on revolution and demanded direct action by the government of a magnitude never before conceived.

The medical profession of Ohio was aware of this critical situation and repeatedly offered and pledged its active cooperation and support to official and voluntary agencies concerned with these problems in which, of course, the medical profession itself was intimately and genuinely concerned.

PROFESSION'S RIGHT TO VOICE IN PLAN

Being a humanitarian and altruistic profession, the medical profession has unselfishly rendered service without compensation to many indigents and near-indigents. In recent years, because of distressing economic conditions the charity burden carried by the medical profession grew to enormous proportions. It was not until the profession itself had about exhausted its resources and many physicians were hard-pressed to exist or provide their families with necessities of life that the profession requested some form of financial relief as partial compensation for the gigantic task of providing medical care for the unemployed thousands.

This record was unimpeachable evidence of the genuine interest and concern of the medical profession in the critical problems of relief. Moreover, it gave the profession the right to expect as equitable compensation for services to the indigent as that received by other purveyors of necessities to the same class of citizens. And, furthermore, it gave the medical profession through medical organization the right to expect recognition and consideration as adviser and counsel on medical matters in any relief program arising therefrom.

When after repeated requests from the representatives of medical organization, national and state, the use of Federal funds for medical care to the needy was authorized by the Federal Emergency Relief Administration, the medical profession of Ohio anticipated the establishment in Ohio of a medical plan under the State Emergency Relief Administration that would provide them with equitable remuneration for services to those on the relief rolls and would permit active cooperation between relief officials and members of the medical profession.

HISTORY OF OHIO SITUATION

Members of the State Association are cognizant of the unfortunate and difficult situation which developed in Ohio with the inauguration on September 20 of last year of the medical plan and fee schedule by the State Relief Commission under Rules and Regulations No. 7 of the Federal Emergency Relief Administration.

A detailed history of that situation, which on one occasion prompted the Council of the State Medical Association in an official statement to "view with regret, disapproval and apprehension the accumulated evidence over a period of recent months of the disposition on the part of the State Government and State Administration to ignore important and fundamental phases of medical practice and medical service in connection with governmental functions, public health, public welfare, public safety and medical care", is found in the following references to actions by the Council and the Committee on Public Policy and news articles published in *The Ohio State Medical Journal*:

October, 1933, issue, pages 663-665 and page 648; November, 1933, issue, pages 710-713; December, 1933, issue, page 776 and pages 780-783; January, 1934, issue, pages 39-40 and pages 46-49; February, 1934, issue, pages 102-108; April, 1934, issue, pages 237-238 and pages 242-247; May, 1934 issue, pages 314-317; June, 1934, issue, page 380 and pages 389-392; July, 1934, issue, pages 448-450; August, 1934, issue, pages 528 and 529, and September, 1934, issue, pages 599 and 601.

The foregoing citations present an accurate picture of the almost insurmountable difficulties encountered by the officers, the Council, and the Committee on Public Policy of the State Medical Association in their efforts to have the relief officials of Ohio set up a medical plan which would insure adequate and competent medical care for all on the relief rolls; adequate and equitable remuneration for physicians rendering such service, and the maintenance of the fundamental principles of free-choice of physician and personal and professional relationship between physician and patient.

ATTITUDE OF STATE RELIEF OFFICIALS

Why the state relief officials ignored on numerous occasions over a period of six months the recommendations and suggestions of officials of the State Medical Association for equitable adjustments in the medical fee schedule and for

improvements in the medical plan has never been satisfactorily explained.

Why repeated requests from officials of the State Medical Association for a hearing before the entire State Relief Commission for the purpose of explaining the medical viewpoint on the important problems arising under the medical plan were never granted remains unanswered.

Why officials of the State Relief Administration have not welcomed and never sought the advice, assistance and cooperation of the representatives of organized medicine on medical problems and medical details in connection with the relief program is not known.

No satisfactory explanation has ever been offered by officials of the State Relief Administration why the medical care phase of the state relief program has been inadequately financed and looked upon as merely incidental; why the organization of medical advisory committees in the different counties, as contemplated in Rules and Regulations No. 7 of the F.E.R.A., has never been carried out, and why the state medical advisory committee, organized to assist the State Relief Commission on medical matters, has held but two meetings, both within a month after the medical plan was inaugurated in September, 1933.

CONTINUED, VIGOROUS ACTIVITY IMPERATIVE

But even working under the handicap of these circumstances, the Committee on Public Policy and officials of the State Association were able to bring about some changes in the medical relief plan to make it more equitable and more effective. Everything accomplished in the way of improvement or correction in the fee schedule and plan was brought about under adverse conditions through vigorous action on the part of the officers, the Council, and this committee, and concerted activity on the part of the component county societies and individual physicians.

Our experience with this one important question should do much to awaken us to a full realization of the value of organized action and warn us that we must act as a unit, not expecting a few volunteers to do the work that is the responsibility of medical organization as a whole.

Important medical problems in connection with the poor relief program are still unsolved. Unless present signs fail, the relief program, including provisions for medical care, will be more than "emergency and temporary". It is doubtful if the old systems of providing relief for the poor and needy, shelved when the present centralized plan was adopted, will soon be revived. And incidentally the old system, even in normal times, had many glaring faults. At any rate, it is vital the medical profession insist that in any permanent relief program worked out, medical care to the poor be recognized as a responsibility of the public and that adequate provision be made for remunerating physicians for rendering such service.

For that reason, it is important and imperative that we continue with our efforts to overcome the difficulties referred to above; insist pending problems be solved in a satisfactory way; educate public officials connected in any way with functions affecting medicine to appreciate the services of the profession and the value of the profession's advice and assistance on medical matters; and prove by the character of our services and our professional conduct that we should be looked to for leadership in all medical programs, official or non-official.

INSURANCE SCHEMES; ETHICAL QUESTIONS

Several other developments which have been watched with much interest and some anxiety by the Committee on Public Policy are: (1) the establishment in increasing numbers in various sections of the country of group payment programs for hospital service; (2) the promotion of group sickness and insurance schemes under lay or commercial control; (3) the increasing tendency on the part of some clinics, hospitals, sanatoriums and other semi-public medical institutions to resort to advertising, publicity and propaganda for the sake of stimulating patronage in violation of professional ethics. The following brief comments on these important questions are based on information assembled by the Committee and its conclusions after consideration of the vital points involved.

As programs for the sale of hospital service to groups of individuals under a periodic payment arrangement have been launched in Ohio it is evident that organized medicine in Ohio must give the question its serious thought and study, as the medical profession should be, and is, vitally interested in all proposals affecting the sick. In analyzing any such proposal, three questions of primary importance arise, namely:

1. Is the plan beneficial or contrary to public interest?

2. Is it an entering wedge for state medicine; the practice of medicine by hospitals; and, destructive of the confidential, personal relationship between physician and patient?

3. Is it likely to cause a deterioration of hospital service as a result of competition, underbidding, unethical promotional activities, etc., on the part of hospitals?

The theory behind hospital insurance is to all intents and purposes in accord with sound public policy and a forward step in assisting certain classes of society to meet the costs of sickness. On the other hand there are potential evils in such programs unless they are safeguraded by certain basic principles and regulations. Moreover, we are dubious concerning the prospective enlargement of the idea of hospital insurance because of certain phases which we doubt can be entirely and equitably adjusted in the operation of many such plans.

As emphasized in a statement presented by the

Committee on Public Policy to the Council a year ago and adopted by the Council as an official expression of policy (December, 1933, issue *The Journal*, page 777), any group payment plan for hospital service is contrary to public interest *unless* there is evidence that provision is made for the following:

1. Determination of rate upon basis of accurate actuarial figures.
2. Establishment of adequate reserves.
3. Sufficient spread of the field so that disaster to any one group will not destroy the reserves of the insurer.
4. Selling of insurance only when adapted to the individuals it aims to serve.
5. Definite provision that medical service will not be included at outset or any future time.

The statement also summarized in a general way some of the practices likely to creep into some hospital insurance schemes which would be highly objectionable and responsible for bad results, such as: Limitation of free choice of physician, underbidding, destructive competition, unethical solicitation of patients, disruption of the relationship between physician and patient, exaggeration of the demand for hospitalization, etc.

It is almost inconceivable that in any hospital insurance plan there can be a complete separation of hospital service and medical service. Even should a plan be devised wherein medical and hospital services are completely divorced, there is insufficient assurance that complete or partial medical service will not be included as one of the benefits of the plan at some future date.

We see many serious angles to the question of hospital insurance and support the Council of the State Association in recommending that the component county medical societies give the question their earnest thought and study and refuse to sanction any hospital insurance project until absolutely convinced of its soundness in all respects and the particular plan has been acted upon by the Council.

A number of component county medical societies and academies of medicine have sought the advice of the Council and the Committe on Public Policy regarding various group insurance and mutual benefit proposals for financing medical bills.

After reviewing data from various sources and carefully analyzing several such proposals, the Committee on Public Policy presented to the Council in March of this year, a statement of policy and principles regarding group and mutual medical insurance proposals generally, which statement was adopted by the Council. (April, 1934, issue *The Journal*, page 239).

That statement raised numerous pertinent questions concerning such proposals and pointed out the evils which might exist in many of them. The conclusion of that pronouncement of policy we believe to be especially important. By way of emphasis it is repeated herewith:

"It is the sense of the Council of the Ohio State Medical Association that before county societies or academies of medicine approve of, or lend support to, group insurance plans under lay or commercial control, serious consideration be given to the implications contained in any program which would supersede private medical practice or establish a middleman service between patient and doctor. The Council is not convinced from information and data at hand that private medical practice when ethically and efficiently conducted has failed to meet social, economic and medical demands of a community."

UNFAIR PRACTICES OF CLINICS CONDEMNED

Evidence of the increasing seriousness of the question of unethical and unprofessional practices on the part of some groups, clinics, and medical institutions is the fact that the number of inquiries, complaints and demands with respect to this question received by the Judicial Council of the American Medical Association increased many fold during the past year.

As substantiating evidence is the fact that the Council of our own State Association during the past year has had to deal with an increasing number of inquiries and complaints of this nature and the fact that at the Cleveland meeting of the American Medical Association in June an unusual amount of time and consideration was given to this question by the House of Delegates of the A.M.A.

Incidentally, a resolution condemning advertising, publicity and propaganda by certain clinics, groups and institutions in violation of proper ethical and professional restrictions placed on individual physicians, adopted by the Council of the Ohio State Medical Association (April, 1934, issue *The Journal*, page 239), was presented to the House of Delegates of the A.M.A. by the Ohio delegation and officially adopted by that body. (June 30, 1934, issue *The Journal of the American Medical Association*, pages 2201-2202).

The sentiments expressed in that resolution were corroborated in the annual report of the A.M.A. Judicial Council which emphatically stated that "there is but one code of ethics for all, be they group, clinic or individual and be they great and prominent or small and unknown". (July, 1934, issue *The Ohio State Medical Journal*, page 445, and May 5, 1934, issue *The Journal of the American Medical Association*, page 1497).

A further indication of the determination of organized medicine to prevent if possible unfair competition on the part of groups, clinics and institutions with private physicians was the action taken by the House of Delegates of the A.M.A. in adding to Chapter 1 of the Principles of Medical Ethics the following section:

"The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors, each of

whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligations they assume when entering the profession."

In the opinion of this Committee adequate legislation and precedent exist for seriously retarding, if not eliminating entirely, this insidious movement on the part of some organizations and institutions to compete unfairly and unethically with the physician in private practice.

Application of the remedy lies with the county medical societies and academies of medicine. Procedure against members for violation of the Principles of Medical Ethics is the duty of the county medical society in the first instance. Unless the county societies have the courage and initiative to take appropriate action on such matters, we may expect few, if any, beneficial results from the foregoing actions taken to stimulate activity and strengthen the foundations for discipline of persistent violators.

LEGISLATIVE PROBLEMS IN OHIO

Because of the critical financial problems of practically every political subdivision and school district of the state, the Ohio General Assembly was in session during the greater portion of the past year, adding greatly to the activities of the Committee on Public Policy and the demands made upon the time of the members of the Committee and the headquarters staff.

The developments in the State Legislature at the various special sessions held since December, 1933, were summarized in a news article in *The Journal* (June, 1934, page 387) which by reference is made a part of this report.

The Committee carefully followed the efforts of the Legislature to solve the revenue-taxation-school problem, being particularly concerned in preventing the enactment of any measures which would have been a duplication of tax impositions upon physicians or discriminatory in nature.

Active interest and cooperation was shown in the legislation making statutory changes in the Workmen's Compensation Law so as to improve the administration of the law, sponsored by the Governor's Investigating Committee on Workmen's Compensation. Recent workmen's compensation developments and legislation are discussed in detail in the combined reports of the Committee on Medical Economics and the Special Committee on Workmen's Compensation, published elsewhere in this issue.

Miscellaneous legislative proposals which affected in any way the medical profession were followed by the Committee and appropriate action taken to protect the interests of the profession.

Through special bulletins and correspondence, the Committee has kept the various legislative committeemen promptly and accurately informed on legislative and political developments. Previous to and since the recent party primaries, the Committee issued bulletins to legislative committeemen suggesting diplomatic contacts with candidates for public offices and advising an active interest in political affairs on the part of physicians as individuals. Between now and the November general election all nominees for public offices should be contacted by members of the profession. Although it is the duty of the legislative committeemen to take the initiative in such activities, they should not be expected to shoulder all the burden and are entitled to the active assistance of every colleague.

As pointed out in the statement of policy adopted in July by the Council and referred to earlier in this report, the forthcoming general election is one of fundamental importance. The future relationship between government and citizenship, including the character and system of medical practice, may be determined by the character and ability of those elected in November to various public offices, local, state and national.

For this reason, the Committee on Public Policy cannot emphasize too strongly the vital importance of personal interest and organized activity on the part of the medical profession with respect to the functions of government and legislative questions during the ensuing year.

The Committee on Public Policy, as in the past, will make every possible effort to effectively represent the sentiment and best interests of the membership in its direct contacts with government officials and members of the State Legislature.

However, as has been repeatedly emphasized, physicians as leading citizens in their respective communities and through their county medical society can exert a greater and more lasting influence on public officials and public affairs than this Committee or any other small group of physicians can hope to do. The attitude of legislators toward the medical profession is actually determined by local contacts and local situations.

We will continue to do our part in as effective a manner as is humanly possible but we are frank to say that the successes of the medical profession in all types of public activities will be in ratio to the degree of concerted activity and interest displayed by the profession as a whole and not the work and energy of a comparatively few.

— OSMJ —

Licenses through reciprocity to practice medicine and surgery in Ohio have been issued to the following by the State Medical Board: Dr. Frank G. Grace, Delaware, Northwestern University; Dr. Abe A. Hopps, Cleveland, Meharry Medical College, and Dr. William F. Hulse, Cleveland, University of Michigan.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

(Including the Report of the Special Committee on Workmen's Compensation)

J. Craig Bowman, Chairman, (1936) Upper Sandusky
A. B. Brower, (1934) Dayton
E. O. Smith, (1935) Cincinnati
B. J. Hein, Chairman, Special Com. Toledo
L. L. Bigelow Columbus
Don K. Martin, Secretary Columbus

Increased interest and activity in the field of medical economics throughout Ohio during the past year, on the part of lay interests as well as the medical profession itself, have created innumerable new and complicated problems for organized medicine.

Obviously, the past year has been a particularly busy one for the Committee on Medical Economics since the primary function of the committee is to assemble data on various phases of this subject, study and analyze such information collected, and formulate suggestions and criticisms on the social and economic aspects of medical practice.

This committee has received valuable cooperation from the Committee on Public Policy in determining the policy and procedure which should be adopted in handling some of the vital questions considered. In turn, we have assisted and cooperated with the Committee on Public Policy on several problems before that committee. In many instances the duties of these two committees have been overlapping and a coordination of our activities has been necessary to secure satisfactory results.

The Committee on Medical Economics has worked jointly with the Special Committee on Workmen's Compensation, appointed upon authorization of the Council. We have supplied the special committee with information on workmen's compensation questions collected over a period of years by this and previous committees on medical economics and on contacts with the State Industrial Commission and other organizations and groups interested in workmen's compensation matters.

The activities of the Special Workmen's Compensation Committee are summarized here as part of a joint report, together with some of the experiences and observations of the Committee on Medical Economics on workmen's compensation questions.

However, before passing to a discussion of workmen's compensation developments, we desire to comment, chiefly for the purpose of emphasis, on a few factors which must be kept in mind by the medical profession in its efforts to work its way out of the maize of uncertainty, adversity and impending dangers the past few years have produced.

NEW FORMS OF MEDICAL SERVICE MULTIPLY

Exemplifying the trends and tendencies ushered in with the collapse of the boom period and the beginning of the present era of social and economic changes, there has been a marked increase in the number of proposals and schemes offered by individuals and groups, within and outside the medical profession, to modify the established form of medical practice.

Some of these proposals involve types of organization and methods of practice which are contrary to the generally accepted views of the profession on what constitutes satisfactory medical service and the principles of medical ethics.

To quote from the last annual report of the Bureau of Medical Economics of the American Medical Association:

"The methods adopted are those of desperation. In these instances one is justified in raising the question whether a temporary expedient will bring to the public and to the medical profession greater benefits than are represented by the social values of medicine which some of these plans are sure to destroy."

It is not difficult to understand some of the reasons for the tremendous increase in the number of questionable programs for supplying medical service.

Stimulated by radical social and economic changes and the restless state of mind of a considerable portion of the public, energetic and influential interests and individuals have seized this opportunity to promote fantastic and commercialistic projects in the field of medicine which, undoubtedly, would have received little, if any, public support in normal times.

Then too, because of unfavorable business conditions, resulting in loss of patronage and serious financial problems for most members of the medical profession, little difficulty has been encountered by promoters and exploiters in interesting a sufficient number of physicians to operate their schemes.

Commitment of the present national administration to an extensive social welfare program, including medical service, has added impetus to various movements to establish new forms of medical practice, most of which would abolish the personal relationship between physician and patient and professional control of the practice of medicine.

What the ultimate outcome of the crisis now

confronting the medical profession will be is problematical.

PRINCIPLES MUST NOT BE SURRENDERED

If the present trend toward socialization, governmental regulation, regimentation, and centralization continues and disregard for fundamental principles in planning for the future persists, it is doubtful if unwise and ill-advised, as well as detrimental, changes in the nature of medical practice can be prevented. Even the influence of a united medical profession cannot hope to cope with the politician and the theorist as long as the latter are able to mislead the public with high-sounding phrases and insidious propaganda.

However, the situation is not as hopeless as some would have us believe. There are strong and numerous indications of increasing discontent and disgust on the part of the public with respect to the present mania for experimentation and tinkering. The over-worked theory that expediency must be the guiding factor in the solution of the nation's problems has lost much of its false appeal. Many are beginning to yearn for the day when public questions will again be decided in accord with basic principles and proven theories. The public does not appear so keen about accepting without question anything and everything which happens to be labeled "new" or "emergency". Ballyhoo no longer has the appeal it had when the public mind was confused and little logical thinking was done.

During the ensuing critical period when the public will be called upon to make a final decision on many questions vitally affecting medical service and medical practice, it is of the utmost importance that there be unison of thought and activity on the part of the medical profession. We dare not let ourselves be misled into compromise or coerced into surrendering any of the principles which we know to be the only safeguards to the public health and the professional status of medicine. We must stand securely and unitedly by those principles and the policies based upon them. We must not make the fatal blunder of playing into the hands of the politician, commercial promoter and proponents of social medicine by supporting any proposal or project we know to be basically in conflict with sound economic, scientific and ethical principles. We should demand that any changes in the nature of medical practice found necessary and advisable now or in the future conform to the sound principles so well established. In any case, we must avoid prejudicing ourselves in future negotiations by taking any position or offering any "plan or plans", under the stress of coercion or expediency, which would weaken our position and by implication commit us to general policies with which we are in distinct disagreement.

The responsibility of every physician is great in the fight organized medicine must make to prevent irreparable harm to scientific medicine. Personal views and opinions on public affairs must not be permitted to alter our belief and faith in the principles underlying the individualistic practice of medicine. This is no time for thought of personal prestige, financial gain, or political preferment.

If every physician would observe in all respects the principles of professional ethics and refuse to be tempted into participating in schemes and projects which compel him to violate such principles, the promoters and exploiters would have to seek new fields of activity. It is time for the medical profession, through medical organization, to go to the mat with those physicians who by selling their professional services and reputations to the racketeer and exploiter contribute to a condition which jeopardizes the future of the medical profession as a whole.

CODE OF ETHICS FUNDAMENTALLY SOUND

There are various types of organizations, involving contract practice, industrial practice, hospital, group and clinic practice, and practice of medicine by corporations, which should be carefully scrutinized by the profession. Physicians involved in projects found to be objectionable and competing unfairly with physicians in private practice, should be given the choice of severing their connections with such activities or face disciplinary action.

The ethical principles which guide medicine are fundamentally sound and are sufficiently clear to be understood by any physician. For example, no physician should have any difficulty interpreting the following provision in the Principles of Medical Ethics regarding contract practice, as amended at the recent Cleveland meeting of the American Medical Association:

"By the term 'contract practice' as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita.

"Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. . When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy.

"Each contract should be considered on its own merits and in the light of surrounding conditions.

Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole."

Moreover, no physician should find it difficult to understand the very definite reference in the Principles of Medical Ethics to physicians who hire themselves to organizations incorporated to engage in the practice of medicine and exploit the services of these physicians unethically to the public. The Principles of Medical Ethics on this question say:

"It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound policy."

These and other provisions of the code of ethics show that existing principles are adequate to keep the profession on solid ground and are adaptable to meet most any situation arising in medical practice. They must be observed and enforced if genuine and lasting good is to result from them. Here is an opportunity for each county medical society and academy of medicine to perform an important function.

One big issue before the medical profession is whether or not the practice of medicine shall continue on a professional, individual and competitive basis, rendering competent medical service to all who require it.

If so, the principles on which scientific and professional medical practice is based must be observed, preserved and enforced. The type of organization set-up to provide medical service may be relatively incidental to the principles which insure high quality of the service, free choice of physician, unrestricted competition, intimate personal relationship between physician and patient, and the inseparable fundamentals herein enumerated.

Public opinion may ultimately bring about radical changes in the present system of medical service. However, whatever happens the medical profession will be in a stronger position to defend the principles of scientific medicine and insist that they be observed if it refuses to retreat from the intent and spirit of those principles than by relinquishing control of medicine to outsiders through compromises or acquiescence to unsound theories and programs.

WORKMEN'S COMPENSATION DEVELOPMENTS

As those who have read the special articles and minutes of the meetings of the Council published in *The Ohio State Medical Journal* already know, numerous important developments bearing on the administration of the Ohio Workmen's Compensation Law and of direct interest to the medical profession have taken place during the past year.

The Committee on Medical Economics, as in previous years, has followed these developments closely; assisted in representing the interests of the medical profession in negotiations involving in any way the medical aspects of the workmen's compensation system; and has been in constant direct contact with the State Industrial Commission.

As was pointed out in the report submitted by the Committee on Medical Economics to the membership a year ago, the State Industrial Commission has been for several years confronted with serious financial and administrative problems and difficulties. (September, 1933, issue *The Journal*, pages 566-568). This situation, so serious at times as to jeopardize the entire workmen's compensation system, has been largely responsible for the increase both in number and importance of the medical problems in connection with the handling of workmen's compensation claims.

In January of this year, an investigation of the whole workmen's compensation system was launched by a special investigating committee appointed by the Governor. (March, 1934, issue *The Journal*, pages 171-173). The investigation was prompted by the discovery of serious irregularities in connection with the reporting of payrolls on the part of some employers, involving collusion on the part of several employes of the Division of Workmen's Compensation, and public charges of widespread abuses of the compensation fund and inefficiency in administration of the compensation law.

Shortly after the Governor's Investigating Committee on Workmen's Compensation had started its investigation, it requested the Ohio State Medical Association to submit for its consideration recommendations, suggestions and criticisms on workmen's compensation matters. Previously, friendly contacts with the investigating committee had been established by officials of the State Medical Association and the cooperation of organized medicine in bringing about constructive changes in the compensation law and administrative procedure tendered the committee.

Several joint official and informal conferences were held by the Governor's committee and the Special Workmen's Compensation Committee of the State Medical Association, appointed in October, 1933, (December, 1933, issue *The Journal*, page 778) upon authorization of the Council to carry on negotiations with the State Industrial Commission on medical problems and follow-up recommendations which had been made by a pre-

vious special committee on workmen's compensation of the State Medical Association. (June and July, 1933, issues *The Journal*, pages 377-380 and 441-444).

Following a thorough study of many angles of the workmen's compensation question and an analysis of voluminous information and data, the Special Workmen's Compensation Committee, consisting of Dr. B. J. Hein, Toledo, chairman, Dr. J. Craig Bowman, Upper Sandusky, chairman of the Committee on Medical Economics, and Dr. L. L. Bigelow, Columbus, a former president of the State Association, submitted a preliminary report to the Governor's committee, setting forth a number of recommendations and suggestions for improvements in the workmen's compensation system. (May, 1934, issue *The Journal*, pages 318-320).

STATE MEDICAL ASSOCIATION'S RECOMMENDATIONS

The chief recommendations made by the special committee of the State Medical Association were, briefly: Establishment of regional medical boards of review to review, pass upon and determine chronic, prolonged, unusual or revived cases; assignment of an auditor to the Medical Department of the State Industrial Commission to have charge of the routine audit of medical and hospital bills; stricter enforcement of the Rules and Regulations governing medical, hospital and nursing services, put into effect on September 15, 1932; tabulation of the average length of treatment, number of dressings, period of hospitalization and convalescence, length of disability, and other major factors in common types of injuries and disabilities to aid in the determination of usual medical costs and compensation; a study of the problem of aggravation of pre-existing conditions such as arthritis, syphilis, etc.; better coordination between departments at the Commission and provision for a central clearing house for correspondence; prompt prosecution of flagrant violators; vesting of greater authority in the local regional offices, and statutory changes which would promote greater efficiency in administrative procedure.

Following further investigations and conferences, the special committee of the State Medical Association in July of this year filed with the Governor's committee a second and supplemental report, incorporating additional constructive recommendations and expanding on some of the suggestions made in the previous report.

In both reports submitted by the State Medical Association to the Governor's committee it was emphasized that the recommendations made by the State Association committee should be considered as general and basic. It was pointed out that it would be inadvisable to set forth a definite program and details for carrying out the recommendations until after certain administrative problems had been solved and necessary readjustments made.

However, the special committee expressed the hope that it would be called upon later to elaborate on its general suggestions and offered to cooperate to the fullest extent with the State Industrial Commission and its administrative secretary in working out the details of the general recommendations which we submitted in both reports.

STATUTORY CHANGES ARE MADE

Members of the Special Workmen's Compensation Committee, the Committee on Medical Economics, and officials of the State Medical Association assisted the Governor's committee during two special sessions of the State Legislature in promoting changes in the Workmen's Compensation Law in the interest of administrative efficiency. One of the measures enacted provided for the transfer of the personnel of the Division of Workmen's Compensation from the jurisdiction of the Director of Industrial Relations to the State Industrial Committee and granted the Commission complete authority and supervision over all employed under the workmen's compensation system. Another measure appropriated an additional $125,000 for operating expenses and for employing additional personnel for the undermanned departments under the Commission. (June and August, 1934, issues *The Journal*, pages 387-388 and 530-531).

The final report of the Governor's committee, including additional recommendations for administrative and statutory changes, is now being drafted for submission to the Governor and the 91st General Assembly which will convene in January, 1935. The Committee on Medical Economics and the Special Workmen's Compensation Committee will continue to maintain close contact with the Governor's committee and the State Industrial Commission to assist them on administrative problems in which medical questions occur and represent to them the opinions and viewpoints of the medical profession. In addition, legislative proposals on workmen's compensation matters will be watched closely and the viewpoint of the profession expressed on all measures when and if such action is considered necessary and advisable.

CONTINUED COOPERATION ESSENTIAL

We cannot emphasize too strongly the statement made in the preliminary report of the special committee of the State Medical Association to the Governor's committee that the medical profession in common with other groups is sincerely concerned with the principles underlying the workmen's compensation system and desires to cooperate in efficient, honest administration of the system. The importance of competent medical

service and accurate, honest medical information in connection with industrial disabilities is apparent. For this reason, the responsibility of the medical profession in seeing that the system operates effectively and equitably is great. Abuses on the part of any physician should not and cannot be condoned. It is the duty of organized medicine to assist in every way possible in eliminating abuses and cooperating heartily with the Industrial Commission on methods of procedure designed to strengthen and improve the administrative machinery.

It is our opinion that the medical profession of Ohio generally has the good will and confidence of the State Industrial Commission. In our numerous contacts and conferences with the Commission, we have found the Commission willing and anxious to deal squarely and honestly with the medical profession. At the same time, the Commission expects fair treatment and cooperation from the profession, and justly so. We have found the same attitude prevailing among the official representatives of industry and labor with whom we have had frequent conferences to discuss workmen's compensation questions.

During the past year, several conferences have been held by representatives of the State Medical Association and the State Hospital Association for the purpose of discussing common problems on workmen's compensation and other matters. These have resulted in a mutual understanding of the problems of both groups and made possible a cooperative effort to solve workmen's compensation problems in a way satisfactory to both interests, as well as the Industrial Commission.

* * * *

In conclusion, we emphatically urge every county medical society and academy of medicine to give the economic aspects of medical practice the consideration they should have. It is important that each society or academy have a committee to which economic questions can be referred for study and which can recommend ways of handling local situations for the guidance of the society and the members individually. Provision should be made for discussions of some of the serious economic questions confronting the profession at regular meetings for the information of the members and to obtain the concensus of the members concerning them. As one writer has aptly expressed it: "Let us consider carefully, act with caution, reserve judgment, and speak with one voice for the truth".

ANNUAL REPORT PUBLICATION COMMITTEE

ANDREWS ROGERS, Chairman, (1934)....Columbus
A. B. DENISON (1936).....Cleveland
GILBERT MICKLETHWAITE (1935).....Portsmouth
DON K. MARTIN, Secretary.....Columbus

The indispensable part that a publication such as *The Ohio State Medical Journal* plays in the program and activities of an organization such as The Ohio State Medical Association was evidenced to an unusual degree during the past year marked by sudden and important developments directly affecting the practice of medicine and of special significance for the physician as an individual.

The past year is conceded to have been one of the most difficult periods for the medical profession in all history. Economic, social and governmental readjustments involving in many ways scientific medicine and medical practice have kept the profession in a state of uncertainty and anxiety; occasionally, bewilderment.

Because the medical profession in Ohio was farsighted enough to formulate and place on an efficient basis, a strong, central organization it has been ably represented and everything possible was done to safeguard its interests in the momentous developments of the past twelve months.

Much that was accomplished resulted from concerted activity on the part of the profession in all parts of the state and from local efforts in support of policies and principles formulated to guide negotiations on state-wide questions.

VITAL INFORMATION FURNISHED TO MEMBERS

It is doubtful if the efforts of the State Association or of the various local units would have accomplished so much had the columns of the *Ohio State Medical Journal* not been available for the dissemination of information to the membership at large on the serious questions under consideration and to arouse active, concerted activity among the physicians of the state.

The Committee on Publication, charged with the responsibility of assembling, editing and supervising the publication of *The Journal*, has endeavored to cooperate in every possible way with the officers and committees of the State Association in their efforts to solve the serious problems confronting the profession. We have tried to make each issue of *The Journal* a source of accurate and authentic information on developments of particular interest to the profession. We have endeavored to analyze new problems and their ramifications for the benefit of the membership in the light of their effect on medical practice by publishing frequently carefully prepared articles in which emphasis and

interpretation were given to the established policies and principles of organized medicine concerning such problems. Numerous digests of legal and court opinions of interest to physicians; summaries of new legislation and regulations; and reviews of social, economic and governmental happenings in this and other states have been published. The work of the officers and committees of the State Association has been reported from time to time and special effort has been made to keep physicians informed regarding the activities of their colleagues through the publication of news items about physicians, hospitals and public health departments, as well as the programs and activities of the various county medical societies and academies of medicine.

FILES OF JOURNAL ESSENTIAL

Because *The Journal* is a detailed record of the activities, transactions and proceedings of the State Association—in effect a history of events and developments in the field of medicine or affecting medical practice—it is most important that each member maintain complete annual files of issues of *The Journal.*

Each member should preserve carefully each issue and at the end of each year have the twelve issues bound in volume form. An expensive binding need not be used; any kind that will preserve the copies and keep them in order will serve the purpose.

Unless a member keeps in bound form his copies of *The Journal,* he will have difficulty in keeping himself fully and accurately informed on the activities and policies of the State Association.

In presenting information and comments on the activities of the State Association and on events and developments in which the medical profession is interested, it is found necessary and expedient to make use of the reference method of informing members of past activities and standing policies bearing on questions under discussion. Frequently, reference is made to previous articles, minutes of Council or House of Delegates meetings, or reports of various committees published in *The Journal* to aid the reader. These references are in most cases by issue and page number for the sake of brevity and to avoid repetition. Therefore unless each member has a complete file of *The Journal* for each year he will be handicapped in following the activities of the State Association, in keeping his memory refreshed regarding policies on important questions, and understanding comments made from time to time which are based on these policies, cited by reference. Moreover, because of the voluminous correspondence handled daily by the State Headquarters Office it is found necessary to answer many of the inquiries made by members by referring them to issues of *The Journal* in which the detailed information they request has been published.

Because the committee *does* present in each issue of *The Journal* as complete and comprehensive a report as possible on events and developments directly affecting medicine, we believe the physicians of Ohio are better informed than those of many other states on the acute questions confronting the profession and that unity, harmony and concerted activity on the part of the membership of the Ohio State Medical Association has been greatly stimulated.

SCIENTIFIC SECTION ON HIGH PLANE

Although the Committee on Publication has devoted a great deal of time and effort in developing and assembling material dealing with economic, social, governmental and organization problems, it has not neglected the task of presenting to the membership scientific material of interest and value. Almost four score scientific papers were published during the past year, dealing with a variety of interesting subjects and offering a fine opportunity for every reader of *The Journal* to add to his scientific and clinical knowledge.

Most of the papers appearing during the past twelve months were read at the last Annual Meeting of the State Association. However, your committee was gratified at the increasing number of original manuscripts offered direct for publication in *The Journal.* We desire at this time to encourage submission of essays, case reports, historical notes, etc., direct to the committee. Undoubtedly, a considerable number of papers read before the county societies and academies of medicine throughout the year merited publication in *The Journal* and we believe should have been published for the benefit of the profession generally.

All papers are carefully and thoroughly scrutinized by the Committee on Publication before they are published in *The Journal.* Each manuscript is judged on its scientific value, literary style and general interest. A system of double editing is used to minimize errors, obtain clarity and brevity, and subject each paper to the judgment of at least a majority of the members of the committee. Papers published previously in other publications or in pamphlet form, or submitted by those who were not members of the State Association were not accepted for publication. This is a long-standing rule of the committee and we will continue to adhere to it.

Incidentally, all papers published in *The Journal* during the past 29 years have been catalogued in a card index system kept at the State Headquarters Office for the convenience of members desiring information about titles, authors

and dates of publication of articles that have appeared in *The Journal*.

ALL ADVERTISEMENTS ARE CENSORED

The committee is as proud of the advertising columns of *The Journal* as any of its other departments. All advertising copy submitted for publication must meet strict tests. It must have the approval of the Cooperative Advertising Bureau of the American Medical Association and the Council on Pharmacy and Chemistry of the A.M.A., and finally of the Committee on Publication, before it is published. Advertising material is judged from the standpoint of the quality and scientific value of the product; the accuracy of the claims made by the advertiser and his reputation; and the style and dignity of the advertising copy. No advertisements are accepted on a contingent or percentage basis. Any concern that passes these strict regulations deserves the cooperation and support of the membership.

The committee is anxious to receive suggestions for improving *The Journal*. *The Journal* belongs to the membership of the State Association and any advice or criticism any member has to offer will be given thoughtful consideration. We are especially anxious to stimulate the submission of news items for use in *The Journal* by a greater number of members. Of course, every county society should designate some member to be responsible for sending an account of the society's activities to *The Journal* each month. Material for *The Journal* should be sent to the State Headquarters Office by the 10th and not later than the 12th day of the month preceding the date of publication which is always the first day of the month.

Recently on his President's Page, Dr. Cummer paid *The Journal* the following compliment:

"All in all, our *Journal* is an institution of great merit, one deserving the enthusiastic interest and support of our members and well worthy of their pride."

Without intending to be immodest, your committee agrees with the President because *The Ohio State Medical Journal* is an acknowledged leader in its particular field and without it, the activities of organized medicine in Ohio would be greatly hampered. It deserves the support and cooperation of the membership. As we emphasized a year ago, the usefulness and character of *The Journal* depend largely on the degree of assistance accorded it and interest shown in it by those it serves.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

J. E. TUCKERMAN, Chairman, (1934)....Cleveland
F. P. ANZINGER (1935).....Springfield
W. H. SNYDER (1936).....Toledo
DON K. MARTIN, Secretary.....Columbus

"Malpractice suits brought against physicians, surgeons, groups or clinics, in which two or more physicians have not played an exciting part are few and far between. Because of this, the most important preventive—or perhaps I better say prophylactic—remedy toward the abatement of these suits, is to institute some active method of procedure within our own ranks to curb and silence loose and malicious tongues from peddling uncalled for and entirely unnecessary innuendoes, or from throwing out suggestions or allegations of negligence, ignorance or wrong treatment."

The foregoing statement by a physician who has devoted considerable study to the problems of malpractice suits and threats against physicians has been chosen by the Committee on Medical Defense as the text of this report, first, because it coincides with the views of the Committee on this serious question, and, second, because it emphasizes one of the principal objectives of the medical defense plan of the Ohio State Medical Association.

The present medical defense plan of the State Association was established in 1916 with a two-fold purpose, namely, the *prevention* so far as possible of unjust and malicious suits for alleged malpractice against members of the medical profession and assisting in the defense of members of the Association named defendants in such actions.

TWO-FOLD PURPOSE OF DEFENSE PLAN

The record of the activities and experiences of the Committee on Medical Defense, charged with supervision of the medical defense plan, during the past 18 years has proved conclusively that the salient feature of the plan is that which deals with efforts to prevent the filing of suits for alleged malpractice and make unpopular and unprofitable threats against physicians for the purpose of blackmail or extortion.

Suits for alleged malpractice against physicians based on substantial evidence of carelessness and negligence on the part of the physician are few in number compared to those instigated in a spirit of revenge or for the purpose of cheating the physician.

Also, it is a fact that a comparatively small number of suits for alleged malpractice filed and

which go to trial result in final judgments against the defendant physician. The large proportion of suits filed are never brought to trial, due largely to the flimsy nature of the charges preferred and the absence of evidence to back up such charges.

However, it is none-the-less a fact that even if physicians against whom suits are filed do finally win or the case never goes to trial, the undesirable publicity, the worry and grief occasioned by suits, or, for that matter, threats of suits, can never be adequately compensated for by any financial protection. Malpractice suits always are undesirable regardless of the outcome and in spite of the fact that they may be wholly unjustified. Moreover, they reflect upon the standing and reputation of the physician sued and upon the standing of the profession as a whole.

Therefore, it should be patent to every physician why the *preventive aspects* of the medical defense plan of the State Association are so important and why in its annual reports and other communications to the membership, the Committee on Medical Defense constantly emphasizes and re-emphasizes how essential it is for the profession as a whole to give its active and wholehearted assistance and cooperation to vigorous efforts to prevent the germination of unjust suits.

TONGUE-WAGGING IS GREATEST MENACE

In our opinion, far too many physicians feel that the chief function of the medical defense plan of the State Association is to assist in the defense of physicians after suits for alleged malpractice are filed. While that is an important feature of the medical defense plan, it is but a secondary part of the two-fold purpose of the plan. Obviously, if suits based on false charges and misunderstandings could be prevented, the burden on the machinery established to aid in the defense of physicians sued would be considerably lightened and the public's estimation of the profession as a whole would be greatly enhanced. We dare not discount the need for and importance of more effective organized effort on the part of the profession to keep suits and threats from originating and to constantly wage a campaign of elimination against the causes and bases of such actions.

To act intelligently and effectively in an attempt to strike at the root of the malpractice situation which, as records and statistics in possession of the Committee on Medical Defense indicate, continues to be serious and alarming, the medical profession must have a thorough understanding of the various causative factors in malpractice suits and threats.

As intimated in the opening paragraph of this report, most suits and threats against physicians are incited by unnecessary or malicious tongue-wagging on the part of members of the profession themselves.

It has been estimated conservatively that 75 per cent of the suits for alleged malpractice are inspired or receive some impetus from thoughtless, critical or disparaging remarks of physicians concerning colleagues or their professional skill. For a physician to question before any of his patients the reputation, professional standing or ability of any fellow physician is a dangerous practice. Whatever is said may easily be misunderstood. Misunderstanding is a forerunner of dissatisfaction which frequently is the spark that ignites a malpractice bonfire.

DATA ON CAUSES AND NUMBER OF SUITS

Unfortunately, but true, the records of suits filed and threats made against members of the State Association during the past year show that ill-advised, unjustifiable or loose talk by some physician concerning another was the most serious and primary cause of a great majority of actions. Additional causes of suits and threats were:

Hope by dissatisfied patient and his attorney to profit.

Desire to injure the defendant's professional standing.

Criticism of physician by relatives or friends of patient.

Carelessness or negligence on the part of the physician; superficial examination and service.

Failure on the part of the physician to keep adequate and accurate records.

Negligence on the part of assistants and attendants employed by physician.

Failure on the part of the patient or his family to carry out the physician's instructions and advice.

A considerable number of plaintiffs were indigents or near-indigents and approximately half of the cases upon which suits or threats were based were fracture or suspected fracture cases.

Since the medical defense plan has been in operation, the following suits and threats have been filed with the Committee on Medical Defense:

	Suits	*Threats*
1916-1926, inclusive	141	110
1927	10	9
1928	21	7
1929	23	16
1930	16	17
1931	19	20
1932	13	18
1933	23	3
1934 (January to August)	8	4

Obviously, if the judgments sought in the foregoing suits filed against members of the State Association had been secured, the aggregate financial loss of a part of the profession would have been enormous, amounting to millions of dollars. However, due to effective defense the economic loss has been comparatively small but not nearly so small as it might have been had all members of the State Association given their

wholehearted support to the *preventive program* recommended time and again by your committee.

SOME "EXPERTS" TOO ANXIOUS TO TESTIFY

Before closing our comments on the preventive phases of the medical defense plan, we feel obligated to call the attention of the membership to the fact that few, if any, malpractice actions can be successfully prosecuted without the use of medical expert testimony.

Unfortunately those initiating suits for alleged malpractice seem to encounter little difficulty in obtaining medical witnesses. It is especially regrettable that some members of the profession are always ready and willing to take the witness stand to testify against a fellow practitioner, especially if the plaintiff promises to pay well.

No physician should, of course, perjure himself to defend a colleague or attempt to obstruct the administration of justice. If subpoenaed, a physician should present his honest and conscientious scientific opinion to the court. However, the business of hiring-out to designing attorneys and disgruntled patients is, to say the least, an undignified procedure on the part of any physician. Making medical testimony of this kind difficult to obtain will do much to discourage the filing of malpractice suits instigated in a spirit of revenge or for profit.

LEGAL LIABILITIES OF PHYSICIANS

Some physicians have run into legal difficulties and have even lost in the courts because of ignorance concerning the legal liability of the physician and the obligations he assumes when he undertakes to care for a patient.

To summarize some of the fundamental principles of law and medicine that apply in the relationship between physician and patient:

Legally, a physician is not required to take a case unless he so desires. If he accepts the employment, he contracts to bring to it the average degree of skill, care and diligence exercised by the members of his profession in the same and similar locations or localities, in the light of the present state of medical science. He cannot abandon the case without proper notice to the patient. He must follow the approved methods of treatment, and if there be more than one approved method, he must use his best judgment in determining which method to follow. He must give the patient proper instruction as to the care, attention and caution to be exercised by the patient in his absence. He must attend with sufficient frequency and it is for the physician to determine when no further attention is required. He must use care in the selection of his assistants, or of another to perform an operation which may be necessary. He is liable for the acts of his assistants or for another employed by him, so long as they are jointly engaged, and is liable for the acts of his assistant or intern acting under his direction. Only persons thoroughly competent by reason of education and experience should be employed by him to assist him in the care of patients.

Even should the campaign of prevention we have outlined and emphasized function in the future more effectively than at present, there is little likelihood of complete elimination of suits and threats of suits for alleged malpractice. Therefore, it is vital that the machinery set up under the medical defense plan to provide assistance to members of the State Association in good standing be kept in smooth working condition and that every member of the State Association be thoroughly familiar with the provisions and rules and regulations of the plan.

We are convinced that not all the members of the State Association fully realize the importance of the medical defense plan and the valuable functions it performs in the interests of the medical profession, individually and collectively.

PLAN AS A PROTECTIVE MEASURE

Those physicians who have given themselves the added protection of malpractice indemnity insurance have discovered that the defense plan is an additional and basic safeguard. Many physicians carry malpractice indemnity insurance; many do not. This is a matter to be decided by the individual physician. Of course, it should be understood that the medical defense plan is not, and should not be considered, insurance as this term is applied to indemnity and that it does not permit the State Association to pay court judgments in any case.

The medical defense plan does, however, carry on at all times an organized and vigorous campaign to prevent the filing of suits and eliminate the causes of suits. It provides the machinery for organized assistance in event of suits and for securing corroborative testimony for physicians being sued. It permits the Committee on Medical Defense to aid in the preparation of the defense of a member and to give advice and suggestions gained from experience in similar cases. The plan is elastic enough to permit the Committee to participate in any suit when principles of law affecting malpractice actions are at stake or where an adverse decision would establish a legal precedent involving the interests of the entire profession. In addition, the medical defense plan makes it possible for the Committee on Medical Defense to assist a member who carries malpractice indemnity insurance; to help him in analyzing his contract and policy to see that he is properly covered; and to intercede in behalf of the physician in case of any difficulties between him and the insurance company.

Thus, from the standpoint of prevention, protection and unity of action, as well as advice and assistance, the medical defense plan is of great value to those members who carry indemnity insurance policies and would be of value and importance even if every member carried indemnity insurance.

If a physician carries malpractice insurance he should deal only with indemnity companies

with a sound financial rating and a reputation for honest and fair dealings. Before purchasing such insurance, the physician should assure himself that the policy he is about to purchase covers the situations for which he desires protection and that the contract with the insurance company does not contain loopholes that would permit the company to avoid liability on technicalities. The physician has a right to know, and should insist upon knowing, whether his malpractice insurance policy protects him against all claims arising from his professional activity.

WHAT TO DO IF SUED

When sued, or threatened with suit, a member should immediately notify the Executive Secretary, Ohio State Medical Association, 1005 Hartman Theatre Building, Columbus, Ohio, requesting medical defense blanks. Upon receipt of the blanks, the member should furnish the information requested in duplicate. One of the completed blanks should be sent to Dr. J. E. Tuckerman, 733 Osborn Building, Cleveland, Ohio, chairman of the Committee on Medical Defense, and the other completed blank should be sent to the State Association offices.

The State Association is barred, under the rules and regulations of the medical defense plan, from aid in the defense of a physician if:

1. He is not in good standing (dues fully paid) in his county medical society and therefore not in good standing in the State Association.
2. The alleged cause of the suit occurred or the suit was filed during a period for which the member is or was in arrears with his dues, or in case the alleged cause occurred previous to the defendant's membership in the State Association. (Annual dues in the State Association are always due in advance on or before January 1).
3. He has failed to forward a medical defense application, properly filled out, to the State Association offices within 10 days after the service of summons.
4. He does not take, or have taken, and keep on file, or have available, *X*-ray pictures of fracture cases, unless it can be shown that at the time and place it was impossible to secure an *X*-ray plate.
5. He has been sued on "cross complaint", having filed a suit himself to collect a bill within one year of the termination of his services.
6. He is believed guilty, after careful investigation, of illegitimate professional actions or service.

SELECTION OF LOCAL COUNSEL

If a physician sued is eligible to defense under the medical defense plan, the Committee on Medical Defense engages the necessary legal counsel to conduct his defense. Local attorneys are retained in practically all cases in which defense is conducted by the State Association. However, the designation of local counsel and their employment is entirely in the hands of the counsel for the Committee and no contribution will be made to the expense of legal services unless the attorneys are approved by that counsel.

The Committee on Medical Defense always has insisted that all unjust suits be fought through to the last court, if necessary, to protect the individual physician and the profession against unwarranted actions and accusations. There has been an increasing tendency on the part of some indemnity insurance companies to compromise suits before they go to trial, regardless of the facts or the subsequent effect on the reputation of the physician. This is unfair to the defendant physician and the profession as a whole, and should be condemned and discouraged by the profession at large. Indemnity companies should be made to realize that they are expected to protect the reputation and professional standing of a physician holding an indemnity policy, in addition to meeting judgments. Settlement of suits gives the impression that the physician is guilty of the charges made and is bound to have an adverse effect on his professional standing and reputation.

Indemnity companies frequently seek the advice and counsel of the Committee on Medical Defense and some of them are refusing to issue a malpractice indemnity policy to any physician who is not a member of his local medical society, indicating that such companies realize the additional protection and value offered by the medical defense plan of the State Association and the importance of membership in medical organization.

ACTIVE COOPERATION IS VITAL

In spite of the excellent record of the medical defense plan in protecting the rights, incidentally the pocketbooks, of physicians, there is plenty of room for improvement, especially in the preventive phases of the defense plan. Every physician should take an active interest in this important activity of the State Association. Every county medical society or academy of medicine should devote a part of several meetings a year to a discussion of the malpractice questions and the information disseminated from time to time by the Committee on Medical Defense.

Incidentally, members of the State Association should take an active interest in the defense machinery set up to protect a colleague if sued. Members should give all assistance which they can and which the circumstances permit during the conduct of a case. When the defense is conducted by the State Association whatever service is rendered by fellow-members should be given without thought of pecuniary return. Greater cooperation on the part of all members in this important activity of the State Association, coordination of efforts to make the medical defense plan work effectively, and strict compliance with the warnings and advice repeatedly emphasized by the Committee on Medical Defense will go far toward reducing the malpractice menace to a minimum.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

BEN R. MCCLELLAN, Chairman, (1934).....Xenia
R. H. BIRGE, (1935).....Cleveland
JOHN F. WRIGHT, (1936).....Toledo

This committee has been particularly interested during the past year in developments and activities affecting in numerous ways the relationship between the medical profession and hospitals, both of which are striving to adjust themselves to rapidly changing social and economic conditions.

An analysis of some of the questions confronting physicians and hospitals reveals the distinct need for a closer and more cooperative relationship between these groups and a clearer understanding on the part of both of the motives and activities of each in the present scheme of medical and health service.

It is imperative that both groups heed the advice sounded not long ago by one well-known hospital executive in the assertion that "what we need more than anything else today is keen and farsighted statesmanship in medical practice and hospital administration, which will carry within itself the power to weld seemingly conflicting forces into a unified, organized, cooperative body".

The physician and the hospital have common scientific, professional and economic problems. The hospital cannot exist without the physician. At the same time, the physician needs the hospital in his professional work. Each is an important contributor to the welfare of the community.

During the calendar year 1933, according to a report by the Council on Medical Education and Hospitals of the American Medical Medical Association, (March 31, 1934, issue *The Journal of the American Medical Association*) there were 6,437 registered and approved hospitals in the United States having a capacity of 1,027,046 beds and 52,464 bassinets. During 1933, a total of 7,037,982 persons occupied beds in hospitals. The total patient days in all hospitals numbered 295,748,915. Babies born in hospitals during 1933 totaled 709,276. Physicians having hospital connections numbered 126,261. A total of 4,677 hospitals had *X*-ray departments and 4,324 had pathological laboratories. Hospitals approved for intern training numbered 677, offering 6,074 internships and 370 residencies. Outpatients departments were operated by 2,351 hospitals. During 1933 these departments served 9,519,427 persons who made 32,822,077 visits.

OHIO OUTSTANDING IN HOSPITAL FACILITIES

Ohio ranks high in the hospital field. Hospitals in Ohio approved by the Council on Medical Education and Hospitals of the American Medical Association in 1933 numbered 268, having a bed capacity of 50,715 and 2,546 bassinets. During 1933, 308,774 persons occupied beds in Ohio hospitals. Ohio hospitals equipped with *X*-ray departments numbered 187 and those with pathological laboratories totaled 194. Ninety-one Ohio hospitals had outpatient departments in 1933, serving 435,525 persons who made 1,205,732 calls.

Ohio hospitals approved for intern training in 1933 numbered 37. They were:

City Hospital, Akron; Peoples' Hospital, Akron; St. Thomas Hospital, Akron; Mercy Hospital, Canton; Bethesda Hospital, Cincinnati; Christ Hospital, Cincinnati; Cincinnati General Hospital; Deaconess Hospital, Cincinnati; Good Samaritan Hospital, Cincinnati; Jewish Hospital, Cincinnati; St. Mary Hospital, Cincinnati; Charity Hospital, Cleveland; Cleveland City Hospital; Huron Road Hospital, Cleveland; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. John's Hospital, Cleveland; St. Luke's Hospital, Cleveland; University Hospitals, Cleveland; Woman's Hospital, Cleveland; Grant Hospital, Columbus; Mt. Carmel Hospital, Columbus; St. Francis Hospital, Columbus; Starling Loving University Hospital, Columbus; White Cross Hospital, Columbus; Miami Valley Hospital, Dayton; St. Elizabeth Hospital, Dayton; Elyria Memorial Hospital; Mercy Hospital, Hamilton; Springfield City Hospital; Flower Hospital, Toledo; Lucas County General Hospital, Toledo; Mercy Hospital, Toledo; St. Vincent's Hospital, Toledo; Toledo Hospital; St. Elizabeth's Hospital, Youngstown; Youngstown Hospital.

Hospitals in Ohio approved for residents in specialties numbered 23. They were:

Akron Children's Hospital; Akron City Hospital; Cincinnati Children's Hospital; Cincinnati General Hospital; Cincinnati Sanitarium; Good Samaritan Hospital, Cincinnati; Jewish Hospital, Cincinnati; Charity Hospital, Cincinnati; Cleveland City Hospital; Cleveland State Hospital; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. Ann's Maternity Hospital, Cleveland; St. John's Hospital, Cleveland; St. Luke's Hospital, Cleveland; University Hospitals, Cleveland; Columbus Children's Hospital; Columbus State Hospital; Starling Loving University Hospital, Columbus; Dayton State Hospital; Miami Valley Hospital, Dayton; Massillon State Hospital; Ohio State Sanatorium.

As the foregoing data show, the service rendered by the hospital to the sick and disabled ranks second only to that of the physician and is an invaluable aide to the physician.

MISTAKES MADE DURING ECONOMIC STRESS

Needless to say, during the present period of economic stress and uncertainty a strained relationship has existed in some communities between hospitals and the medical profession. Both

hospitals and physicians have been confronted with critical financial problems.

In an attempt to solve their economic dilemma, some hospitals have resorted to activities and programs which constitute an infringement on the practice of medicine, resulting in unfair competition with physicians in private practice. A few hospitals have disregarded professional and ethical concepts and ignored sound principles of economics in their desperate struggle for business and income.

At the same time we are unmindful that part of the friction which exists in certain localities between hospitals and the medical profession has resulted from thoughtless, ill-advised, selfish and improper conduct on the part of some physicians. Some physicians have failed to realize the seriousness of the situation which has confronted most hospitals and have been reluctant to cooperate with or assist hospital directors in meeting these problems. Such an attitude on the part of physicians is reprehensible.

Hospitals have been subjected to great pressure to experiment in economic planning and to adopt new methods of expanding service and incidentally increasing patronage and income. Some have yielded to exploiters of new social theories and have launched upon programs mechanically impracticable and unsound in principle, despite "go slowly" warnings hoisted by those who have sensed the dangers of exaggeration of the social viewpoint in hospital service.

OPINION OF NOTED HOSPITAL AUTHORITY

No less an authority than Alphonse M. Schwitalla, S. J., Ph.D., dean of the St. Louis University School of Medicine and widely-recognized leader in medical and hospital fields, recently advised those engaged in hospital reorganization activities not to be misled and deceived. In his presidential address at the recent annual session of the Catholic Hospital Association in Cleveland, Dr. Schwittala declared:

"We have been developing in the hospital field, gradually it is true, but with increasing force, the concept of the hospital as a focal point of community responsibility. With this viewpoint in its general implications, we cannot but be in hearty agreement. We have repeatedly in our addresses upon this subject, stressed the idea that the hospital cannot ignore the social trends in a world in which it must labor. The hospital must become more and more the center of community activity in the health and cognate fields. As always happens, however, a new principle or a new restatement of an old principle is but too apt to lead to damaging and, at times, dangerous exaggerations. As I view it, the hospital is essentially the place for the care of the sick; it performs a much-needed, even an indispensable, function in social organization. If the hospital now yields to the socializing tendencies by participation in community plans and projects, by participation in group activities, such as insurance plans, it may be that sooner or later the social viewpoint will be given undue prominence in the policies and the administration of the institution and the medical influence will be relegated more and more into a subordinate position.

"If, therefore, the hospital under the stresses and strains of our present national reorganization yields in an exaggerated fashion to the pressure of these trends, we may reach a point when the hospital becomes the hub for the wheel of the social agency attached to the vehicle of government. In the concept, however, which I should like to emphasize, it is not the social agency but the profession of medicine and more specifically, of organized medicine, which is the wheel rotating about the hub of the hospital. It cannot be too strongly stressed in the face of today's trends, that medicine is the brains as well as the brawn of our institutions. Without the viewpoints and the principles of the science and art of medicine, policies of government and administration, of organization and of hospital management become factors not for the more efficient functioning of the hospital, but for the dilution of that medical influence which it is the obligation of every hospital to assimilate. It must be our purpose to keep medicine and medical care with all that is implied in it, within the focal point of interest in our institutions. The policies of the institutions should be in conformity with the accepted principles of medical practice.

"I am not unmindful of the importance of the social viewpoint in the conduct of the hospital. But in the last analysis, the science and art of medicine, and therefore, also the profession of medicine must be maintained as the central and all-pervasive influence in an institution which seeks to give adequate medical attention to the sick patient. For this reason, too, we cannot but express our misgivings concerning the wisdom of medical societies and other professional medical organizations rushing headlong or even entering deliberately, into socializing plans which in the last analysis, cannot but weaken the foundations of any type of adequate medical care and commit the institution subscribing to such principles to policies concerning medical care which originate in groups outside of the accepted medical organization.

"From a purely social viewpoint, plans for hospitalization insurance, group medical practice, and subsidized or salaried medical care, may be entirely satisfactory or at least practicable. When, however, such social plans and projects are developed without effective and unquestionable safeguards for assuring persistently adequate medical care for the sick patient and without the assurance of the predominant influence of the fully qualified conscientious and progressive physician, then sooner or later such plans become a menace to society because they will destroy those ideals of responsibility which have placed the medical profession upon a pinnacle of altruism, of unselfishness, and of humaneness from which a spirit of commercialism, financial allurements, and selfishness are only too anxious to dislodge it. We must guard against entering into social plans for medical care if those plans imply a diminution in the sense of responsibility or a dulling of the delicacy of the conscience of the physician."

The medical profession is, and should be, deeply interested in developments in hospital administration and policies which might have any bearing on hospital service. With respect to group pay-

ment and insurance plans in the hospitalization of patients, The Council of our own State Association already has expressed an official opinion. (Minutes of October 29, 1933, meeting of The Council, page 777, December, 1933, issue of *The Journal*). We recommend that each member read again the statement adopted by the Council in which certain basic principles were enumerated, pertinent questions raised, and a warning sounded relative to possible premature endorsement.

As we view the situation, what differences there are between the medical profession and hospital authorities are in most instances not the result of disagreements on fundamental principles but are due to misunderstandings and the lack of coordination between the profesion and the hospital administration. We believe that a mutually satisfactory relationship between physicians and hospital could be established in most instances if the following recommendations were adopted and observed:

RECOMMENDATIONS FOR COORDINATION, COOPERATION

1. Every member of a hospital medical staff should abide by the rules and regulations of the institution, realizing that the traditional ideals and motives of the hospital and the medical profession are parallel. He should assist in every possible way the hospital administration in meeting its economic and organization problems so that the institution can serve to a greater degree the needs of the public and facilitate the services of the members of its medical staff.

2. Every effort should be made to establish and maintain harmony and cooperation between the medical staff and the superintendent and hospital trustees. The medical staff should be granted adequate participation in the affairs of the hospital. The staff should be consulted, not dictated to, by superintendent and trustees on professional and scientific matters and permitted to handle such matters whenever possible. Physician representation on boards of trustees is a point worthy of serious consideration, especially in hospitals dispensing charity service, in order that problems of medical service may be equitably solved and conflicting viewpoints reconciled.

3. Diplomacy, consistency and justice should be exercised in the matter of staff appointments. Appointment should be considered on the basis of the physician's qualifications and promotion on the basis of demonstrated ability and actual service, not on acquaintanceship with members of the board of trustees or on the business-getting ability of the physician. Whether or not a physician is a member in good standing in his county medical society should be seriously considered when appointments are under consideration. Few physicians qualified for hospital appointments are not members of their local medical society.

4. Scientific investigation and research in the hospital should be encouraged and adequate facilities for such studies provided.

5. Hospital managements should promptly take disciplinary action against incompetent or unqualified physicians or those guilty of practices not recognized as established and ethical. They should have the support and assistance of medical organization in this matter.

6. Hospital executives should realize that the hospital's first responsibility is to see that efficient hospital care is provided for patients and that they receive the best of medical attention. Overemphasis of the business aspects of hospital management to the detriment of the scientific and professional aspects is bad policy. There is a great difference between sound business methods and commercialization.

7. Financial matters should be discussed frankly between hospital administrator, patient and physician. The patient should know the approximate cost of his hospitalization upon entering the institution. If necessary a deferred payment plan should be worked out whereby both the hospital and the physician could receive pro rata payments from time to time.

8. Unfair competition with physicians in private practice resulting from the operation of hospital clinics and dispensaries should be avoided. The financial status of dispensary patients should be thoroughly investigated before service is rendered. In many instances dispensaries have been expanded to an extent entirely unjustified by the actual needs of the community.

9. The tendency on the part of some hospitals to engage in the corporate practice of medicine through group payment plans or expanding services offered on a flat-rate, all-inclusive basis and to employ physicians on salaries is leading to innumerable complications and practices that are detrimental to the hospital, the physician and the patient.

10. Questions of intern training deserve greater study by hospital executives and staff members. Too often interns are left to shift for themselves and regarded as hired hands. In some instances little effort is made to establish the proper relationship between the intern and the senior staff members. The real purpose of intern training—to make better physicians out of the young doctors—is frequently overlooked by hospital administrator and senior staff member.

11. Both hospital administrators and members of the medical staffs should realize that there is an interdependent relationship between the physician and the hospital. It is not the doctor against the hospital or the hospital against the doctor. Fair play should be the slogan of each.

It is our belief that the medical profession and the hospital owe it to each other and to the public at large to make every possible effort to arrive at

a mutual understanding of the responsibilities of each in working for their common purpose—service to the patient—and to work shoulder to shoulder to maintain this service on an independent, professional and ethical basis.

MEDICAL EDUCATION UNDER SCRUTINY

During the past year, the Committee on Medical Education and Hospitals has endeavored to keep itself informed on the numerous efforts being made in the field of medical education to readjust that important phase of medicine to changing conditions and new social developments. It is quite apparent that medical educators are endeavoring to make the work of the modern medical school meet the requirements of the day. The task is not easy but much progress has been made and even greater advancement is in the offing.

One of the outstanding events of the past year in this field and one which is destined to have a significant effect in molding the character of medical practice in the future is the launching by the Council on Medical Education and Hospitals of the American Medical Association of a comprehensive resurvey of the medical schools of the United States and Canada to determine weaknesses in the present system of medical education and to lay the basis for future training of the medical student. The Association of American Medical Colleges and the Federation of State Medical Boards are cooperating in the study which is now well under way.

To paraphrase an analysis of the aims and purposes of the survey by Dr. Ray Lyman Wilbur, chairman of the Council on Medical Education and Hospitals, the survey will include the following considerations:

1. A better development of graduate instruction so that all physicians may have available opportunity of keeping themselves up to date.
2. To rid ourselves of the antique, the obsolete and the unimportant in our medical courses. To train men how to practice medicine rather than to load them with great masses of information.
3. To arrange for emphasis in the medical school of the newer social concepts for the care of the sick, and particularly the significance of preventive medicine.
4. More adequate study of the normal with its many variations; greater emphasis on the significance of nutrition and growth.
5. Teaching of obstetrics must go beyond the ordinary technics and include the care of the mother for months before delivery; critical evaluation of the use and dangers of anesthetics, instruments and operations.
6. Relationships of dentistry and nursing to medical education.
7. The need for dealing with psychology and aberrations of the mind from entirely new points of view.
8. Relationship of the hospital to the medical school.
9. Emphasis on the significance of medical economics as a part of medical training.
10. Discussion of the often-argued questions of academic appointments and coordination of clinical work with the basic sciences.

This revaluation of medical schools is being undertaken, in our opinion, at an opportune time; when it is essential that medical colleges readjust themselves to new situations and furnish the new generation of physicians with a training which will better equip them to meet these new conditions.

OHIO'S SCHOOLS HOLD HIGH RANK

Ohio's three Class A medical schools should have little difficulty in readjusting their work and structures to meet whatever recommendations may be forthcoming from the national study, for the reason that they have individually and on their own initiative constantly endeavored to respond promptly to new developments in both the scientific and social aspects of medicine. Their adaptability to changing conditions has been unusual and their ability to keep their programs balanced and conservative but at the same time progressive, has won them a position in the front rank of the medical schools of the country.

Shortly before the beginning of the academic year, 1934-35, the Committee on Medical Education and Hospitals requested the executives of the School of Medicine, Western Reserve University, College of Medicine, University of Cincinnati, and College of Medicine, Ohio State University, to furnish it with data regarding their respective schools. The information and statistics secured are herewith incorporated in this report for the information of the medical profession of Ohio as a whole and to present a more complete picture of the outstanding position held by this state in the field of medical education.

WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE

On September 13, 1934, Western Reserve University School of Medicine, opened its 92nd session with an enrollment of 278 students, six more than were enrolled for the year 1933-34.

The following statistics furnished by Dr. Torald Sollmann, dean of the school, on the number of students enrolled and graduated at the school during the past five years show the effects of efforts made to maintain uniformity in class enrollments and the low mortality rate in the student body generally, attesting to the effective methods used in the selection of new students and the success attained in keeping the curriculum from becoming top-heavy and eventually submerging a considerable percentage of the student body.

NUMBER OF STUDENTS

	1934-35	1933-34	1932-33	1931-32	1930-31
Freshman	80	81	79	78	75
Sophomore	68	65	74	60	61
Junior	60	71	55	62	61
Senior	70	55	61	58	58
	278	272	269	258	255

NUMBER OF GRADUATES

1930	54
1931	58
1932	57
1933	61
1934	53

As in past years, the utmost care was exercised in the selection of students for enrollment in the first-year class for the current academic year. For a number of years, the school has required for admission graduation from an approved college or scientific school or equivalent, following completion of a course of at least three collegiate years. This requirement has had a good effect in keeping the standards of those seeking admission high and automatically eliminates from the list of applicants those with lesser premedical credits. However, those eligible for admission are subjected to rigid informal examination, special emphasis being placed on individual factors in the making of selections.

The curriculum given at Western Reserve covers three years of eight and one-half months each and one year of nine months. The total tuition fees for each of the four years are respectively: $442, $435, $415 and $425. The only change of consequence in the curriculum for the 1934-35 academic year is the transfer of the responsibility for the teaching of therapeutics to the Department of Medicine.

The faculty includes 64 professors and 163 lecturers, assistants and others, a total of 227. A number of faculty changes and promotions were made previous to the opening of the current school year, as follows:

Promoted to associate professors: Dr. Samuel W. Chase, histology and embryology; Dr. Emerson Megrail, bacteriology; Dr. O. W. Barlow, pharmacology; Dr. Normal Wetzel, pediatrics.

Promoted to assistant professors: Dr. Raymond F. Hanzal, pathological chemistry; Dr. D. E. Gregg, physiology; Dr. F. C. Bing, biochemistry; Dr. Herbert S. Reichle, pathology.

Promoted to assistant clinical professors: Dr. R. C. McKay, clinical medicine; Dr. D. M. Glover, clinical surgery; Dr. H. L. Sanford, clinical gynecological-urological surgery; Dr. J. L. Reycraft, clinical gynecology.

Appointed instructors: Dr. Harris Connors, dermatology and syphilology; Dr. Josephine K. Dirion, ophthalmology; Dr. M. A. Simon, pathology; Dr. H. H. Brittingham, clinical medicine; Dr. I. H. Einsel, clinical medicine; Dr. W. P. Garver, clinical medicine; Dr. I. C. Hanger, clinical medicine; Dr. A. A. Hill, clinical medicine; Dr. J. J. Selman, clinical medicine; Dr. R. V. Stecher, clinical medicine; Dr. L. G. Steuer, clinical medicine; Dr. H. A. Williams, clinical medicine, assisting in Hanna Division of Clinical Pathology.

The following resigned from faculty positions: Dr. George B. Ray, to become professor of physiology, Long Island College; Dr. W. F. von Oettingen, to become director of the Laboratory of Toxicologic Investigation, DuPont Companies; Dr. Bradley M. Patten, to become assistant director for medical sciences, Rockefeller Foundation, and Dr. David Steel, to enter private practice.

During the past year, the school accepted a grant of $8500 for two years, made jointly by the Beaumont Foundation and Charles L. and Nathan G. Richman and Richard Kohn for the support of experimental pathology.

UNIVERSITY OF CINCINNATI, COLLEGE OF MEDICINE

With a new dean in charge and a freshman enrollment considerably smaller than that of recent years, the College of Medicine, University of Cincinnati, opened its current academic year on September 24, 1934.

On September 15, Dr. Alfred Friedlander assumed the deanship of the college, succeeding Dr. A. C. Bachmeyer who resigned after nine years of service to concentrate on the management of the Cincinnati General Hospital of which he is superintendent. Dr. Bachmeyer will continue his connection with the college of medicine as professor of hospital administration.

As indicated in the following figures on enrollment, the College of Medicine, University of Cincinnati, requires that all students before becoming eligible for a medical degree must complete a year's internship in a hospital recognized for intern training by the Council on Medical Education and Hospitals of the American Medical Association and approved by the executive committee of the medical college faculty:

NUMBER OF STUDENTS

	1934-35	1933-34	1932-33	1931-32	1930-31
Fifth year (internship)	73	72	67	59	57
Fourth year	69	74	74	67	61
Third year	72	68	72	75	65
Second year	79	76	77	75	73
First year	75	91	90	90	90
Special	—	9	3	5	—
	368	390	383	371	346

NUUMBER OF GRADUATES

1930	58
1931	61
1932	60
1933	67
1934	71

According to information furnished by Dr. Bachmeyer before relinquishing the position of dean, the number of students entering the freshman class was reduced by executive action, in part in response to the general appeal that the number of students in all medical colleges be reduced but primarily because of the opinion of the faculty that the classes have been too large and that better instruction can be given the lesser number.

The 1934-35 academic session marked the in-

troduction of the requirement that matriculants present a minimum of three full years of college preparation. Inasmuch as a number of colleges whose students usually enter the University of Cincinnati, College of Medicine, had revised their preparatory courses in compliance with this requirement, this year proved a favorable one to effect a reduction in the number of matriculants.

Dr. Bachmeyer's comments regarding the selection of students for the first-year class are of special interest and are quoted herewith in full:

"The selection of students for the freshman class presents one of the most difficult problems confronting the college administration. Past experience has demonstrated that there is no single criterion or combination of criteria that can be applied with uniform success. Preparatory college scholastic records give some indication of the applicant's mental capacity but it frequently happens that a student who presents an outstanding record fails to achieve success in his medical studies. The advice and counsel of the candidate's premedical instructors is often helpful to the Admissions Committee. If, however, the applicant nominates the instructors whose opinions are to be obtained, the comments are often misleading.

"The Appitude Test for medical students given during the past five years under the direction of a committee of the Association of American Medical Colleges gives some information beyond that contained in the student's scholastic record. Used in conjunction with other criteria it may be helpful. Reports upon its effectiveness would indicate that for the upper and lower deciles of those examined the test is fairly reliable but for 80 per cent of the candidates its predictive value is not very great.

"Personal interviews, between several members of the Admissions Committee or faculty and the candidates are often very helpful. The reactions of the prospective students during such an interview vary greatly. Highly desirable candidates may often show to disadvantage at such times particularly if the interviewer is not skillful and capable in every respect.

"These several measuring rods are capable of indicating fairly accurately the elements of mental capacity, preparation, general knowledge and appearance. They do not, however, give any measure of the student's energy and enthusiasm; his willingness to follow difficult studies consistently and earnestly; his ideals and aspirations; the true reasons for his desire to enter the profession; his culture and general fitness to serve as a physician.

"Our Committee on Admissions has used all of the criteria previously mentioned but readily confesses that it has not found any easy solution of this difficult and important problem. In seeking the counsel of the candidate's premedical instructors it is highly desirable to obtain the consensus of opinion of all of those instructors rather than to accept the report of any one or two of them."

The course offered by the college covers four years of eight months each, and in addition, as previously mentioned, a year's hospital internship. The total fees for the years are—respectively, $360, $370, $360 and $380, and if not a legal citizen of Cincinnati, $50 additional.

No major changes in curriculum have been made this year but it is contemplated that a series of introductory lectures will be given the first-year class in an endeavor to acquaint them with the general field of medicine and assist them in coordinating their studies in the several departments of the college. It also is planned to develop a series of lectures on the History of Medicine during the current session. The college has ample clinical facilities for the instruction of students but is in need, according to Dr. Bachmeyer, of further financial resources in order that those facilities may be utilized to better advantage for both instruction and investigative studies.

The following members of the faculty were lost through death during the past year: Dr. Edmund Baehr, associate professor of physiology; Dr. Roger S. Morris, professor of medicine; Dr. Charles E. Caldwell, emeritus professor of surgical anatomy, and Dr. Augustus Ravogli, emeritus professor of dermatology and syphilology.

Dr. Baehr's position has not been filled. Dr. Joseph L. Donnelly and Dr. Robert Lee Johnston have been appointed instructors in physiology. Dr. Mark A. Brown is acting head of the department of medicine and a committee is engaged in seeking someone to serve as professor of medicine and head of the department, a position vacated by the death of Dr. Morris.

Dr. E. O. Smith, after 25 years of service, resigned as professor of urology because of ill health. His successor is Dr. Gordon F. McKim. Dr. Victor Ray, Sr., resigned as professor of opththalmology. Dr. Clarence E. King was promoted to that position and head of the department. Dr. Frank M. Coppock was promoted to professor of surgery, gynecologic division, and named chief of the division, succeeding the late Dr. Charles L. Bonifield.

The faculty of the college consists of 117 professors and 196 associates, assistants, etc., a total of 313.

OHIO STATE UNIVERSITY, COLLEGE OF MEDICINE

The College of Medicine, Ohio State University, has made good progress in spite of the economic depression, data submitted by Dr. J. H. J. Upham, dean of the college, indicates.

Preparations have been completed for opening

the 1934-35 academic session on October 2 with an anticipated enrollment of 101 freshmen, 97 sophomores, 89 juniors and 90 seniors. The enrollment in the college for the past four years was as follows:

NUMBER OF STUDENTS

	1933-34	1932-33	1931-32	1930-31
Freshman	101	101	100	100
Sophomore	90	85	86	80
Junior	85	88	92	70
Senior	89	90	76	79
	365	364	354	329

NUMBER OF GRADUATES

1930	58
1931	78
1932	75
1933	88
1934	86

The fees for students were raised from $186 to $228 per year. This increase was thought justified on four grounds: The great cost to the state of medical education; the relatively low fees in this college compared to others; the fact that not all students applying can be admitted so the select group should pay a little more proportionately of the expense of instruction; and, the resulting increased income will enable the college to inaugurate improvements which more than repay the students for the relatively small increase.

One of the activities made possible by the increased fees was the opening of the dispensary in the mornings for the benefit of the members of the junior class. This brings these students in direct contact with patients a full year earlier than heretofore.

In view of the large number of Ohio students who apply annually for admission to the college, the first-year class annually is limited to residents of this state.

The matter of selection of the freshman class is taken very seriously by the Entrance Board under the direction of Bland L. Stradley. Several times the number that can be admitted make application every year. Personal interviews are required of all. Scholastic standing, the results of the aptitude and intelligence tests, personal character, family background, geographical location in the state, etc., are taken into consideration for the purpose of selecting those most likely to make acceptable physicians. As a result of this careful selection, during recent years the percentage failures decreased materially. Three years of collegiate work are required for admission.

The faculty consists of 49 professors and assistant professors, 66 lecturers, instructors, demonstrators, etc., a total of 115.

Several months previous to the opening of the 1934 session, the services of Dr. F. A. Hartman, formerly connected with the University of Buffalo, were secured. Dr. Hartman will serve as professor of physiology and head of the department. He is widely known for his studies in regard to cortin; is one of the front-rank physiologists in the country, and is an outstanding addition to the college's research group which has a record of notable achievements during the past few years.

The death of Dr. Ernest Scott, head of the department of pathology, was a great blow to the college not only because of his value as a pathologist and teacher but because of his influence among and inspiration to the student body. Dr. Carl L. Spohr has been named acting head of the department of which Dr. H. B. Davidson is assistant professor and Dr. T. T. Frost, formerly pathologist at the Cleveland City Hospital, is an instructor.

The death of Professor Francis L. Landacre removed from the faculty one of the best known and widely recognized teachers of anatomy in the country. Professor R. C. Baker has been appointed head of that department and secretary of the college, to succeed Professor Landacre.

A third loss by death was that of Dr. A. M. Bleile, professor emeritus of the department of physiology.

Dr. L. L. Bigelow has been appointed a member of the Entrance Board to succeed Dr. Scott.

No changes of any consequence have been made in the curriculum. The course consists of four years of 34 weeks each.

* * * *

In conclusion, we wish to emphasize the importance of continued support and active interest on the part of the profession of the state with respect to the splendid work being done by Ohio's medical schools. They need and deserve the cooperation and assistance of physicians in active practice. In turn, the profession should have the cooperation of the executives and faculty members of each institution in efforts being put forth by organized medicine to solidify the profession and enhance its ability and capacity for meeting critical social and economic problems as well as difficult scientific and medical questions.

In our opinion part of the duty of administrators of the medical school is to acquaint students in training with the social and economic aspects of medical practice and stress the importance of organized effort so that the young doctor is better prepared to become upon graduation a useful and active member of organized medicine and to render assistance in the solution of problems which must be dealt with by the profession as a unit and not as individuals.

Maintenance of the closest relationship between organized medicine and medical schools is essential to keep medical education on a high plane and to keep the ranks of organized medicine recruited with active and informed members.

ANNUAL REPORT OF THE COMMITTEE ON PREVENTIVE MEDICINE AND PERIODIC HEALTH EXAMINATIONS

V. C. Rowland, Chairman.....Cleveland
C. W. Burhans.....Cleveland
Jonathan Forman.....Columbus
Beatrice T. Hagen.....Zanesville
R. R. Hendershott.....Tiffin
A. J. Skeel.....Cleveland
C. I. Stephen.....Ansonia

Mortality and morbidity rates have never been better in the United States, despite the prolonged economic depression, than at present, attesting to the cumulative good effect of the various worthwhile movements for public and individual health that have been carried on over a period of years in a cooperative manner by professional, governmental and lay forces.

Popular health education, like all educational processes, has progressed slowly. However, its good effects have been noted to a marked degree especially during the past few years.

Fortunately, popular health education has continued throughout the period of economic and social unrest. To be sure, unsettled conditions have compelled a retrenchment in many medical and public health activities, even in emergency situations, and has necessarily diverted some attention from the health examination movement and other phases of both public and personal preventive medicine. However, this is a temporary situation. The beneficial results that have been obtained, as evidenced by the low mortality and morbidity rates that have prevailed during the national emergency, will have a tendency to add considerable impetus to health educational activities during the ensuing years.

Essential activities in the field of preventive medicine have been maintained in Ohio during the past year. Some desirable functions and programs have had to be curtailed or abandoned for financial reasons. On the whole, however, Ohio has made a splendid record in spite of unfavorable conditions.

INTEREST OF PROFESSION INCREASES

Official public health activities have been carried on effectively throughout the state although financial resources for public health work in some communities have reached the danger point. The state and district health departments on the whole have done an efficient job, in fact, an exceptional job when the tremendous shrinkage in funds and personnel available for such activities is taken into consideration.

Considerable progress has been made in the field of personal preventive medicine. The medical profession of Ohio has been mindful of the fact that the prevention of sickness is especially vital during periods of financial distress. Preventive mindedness has been disseminated to the public by the practicing physician, not only by formal periodic health examinations but in all his contacts in clinical practice.

It has become more apparent that personal preventive medicine must be looked upon from the broad viewpoint of vital statistics, individual heredity, and physical and mental predisposition, and must consist of much more than a routine physical examination.

In fact, reliance upon a perfunctory physical examination, hastily made, without studying the background of a patient and without anticipating his future trends, has been a definite source of criticism. In certain phases of the health examination movement exaggerated claims as to results likewise discredit the movement.

As a matter of fact, hardly any criticism can be made of a health examination which cannot equally well be made of an illness examination. One hundred per cent health is an ideal rarely attained. Practically all applicants have minor symptoms which should lead to a thorough investigation whether it is labeled a health or a diagnostic examination. Prevention should be the keynote in either case.

The objection that health examinations produce neuroses certainly is a matter of technique. If this is bad the reaction may be quite as severe or even more so in connection with patients who have reasons to suspect a disease as in those who regard themselves healthy.

The criticism that the results of preventive measures are not great may also be applied to curative efforts in many conditions. In the case of preventive work, of course, it is never known what is prevented and the results are never dramatic. Only by following vital statistics over definite periods of time and contrasting the incidence of preventable diseases in other periods or in different communities or countries is it really apparent that preventive medicine is enormously effective.

The advancement of personal preventive medicine through the periodic health examination and other acceptable methods must continue. Experience has shown that the beneficial results greatly outnumber the criticisms that have been raised, most of which can be met by improvement

in technique and a better understanding of the whole movement by the public at large.

Education of the public on medical and health matters is an activity that merits greater consideration than is sometimes given to it. Much inaccurate, misleading and harmful information on these questions is now being issued to the public by quacks, faddists and exploiters of patent medicines, foods, cosmetics, etc. Those interested in seeing that the people are correctly and advisedly informed on medical and health matters should do everything possible to counteract the activities of individuals and groups attempting only to reach the pocketbooks of the people by appealing to their interest in the maintenance and restoration of mental and physical health. The two most effective methods of providing the public with accurate and authentic information are: (1) Dissemination of carefully prepared data through the press, radio and addresses before lay groups by official public health departments; and, (2) Dissemination of information and advice by the physician in private practice to his patients.

Organized and spectacular programs in popular health education are effective if properly handled. An example is the remarkable medical and health exhibit staged this year and last at the Chicago Century of Progress Exposition. This exemplified the progressive spirit in preventive medicine and was the type of public demonstration that accomplishes beneficial results. Preventive medicine was especially stressed in the Chicago exhibit. To quote from an announcement:

"The object of the exhibits on health education by the visual and auditory methods are: (1) To compare health conditions of a hundred years ago with those of today; (2) to instruct the public in the intricacy of the living human machine and to give warning not to meddle with it by dangerous self-medication; (3) to interest the layman in the scientific story behind the physician's services and opinions regarding health and sickness; (4) to show that compassion for suffering humanity and not commercialism rules the lives of the great discoverers and practitioners of medicine; (5) to prove to the public that many chronic diseases, such as cancer, tuberculosis, heart and kidney disorders, and diabetes, are preventable and if detected early by a periodic health examination are curable; (6) to show the layman the value of discrimination in selecting one to evaluate health and detect the presence of disease and that the knowledge and developed skill of the duly qualified doctor is the patient's only safeguard and bulwark in the prevention and cure of diseases."

It is recommended that all interested in health educational work read carefully an article in *The Journal of the American Medical Association* (May 19, 1934, page 1707) describing the Chicago exhibits and discussing the technique of giving exhibits, attracting attention and driving home an important truth.

The Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical Association has watched with much satisfaction the progress made and the progressive spirit being manifest in the field of public and personal preventive medicine. It has been actively engaged in promoting the cause of preventive medicine in Ohio, especially the matter of stimulating greater interest and activity among the medical profession of the state in this phase of medical practice.

To reemphasize the advice that has been given the profession on repeated occasions, the physician in private practice must be equipped and willing to include the practice of personal preventive medicine in his everyday practice. He should be interested in educating the public as to the value of health examinations, vaccination and immunization, and other phases of personal preventive medicine and especially enthused in preparing himself to render these services when requested. Public education, especially the publicity angles, is a matter that should be handled by official public health agencies and responsible lay groups. Of course, these organizations should be willing to accept suggestions and advice from medical organizations on any activities undertaken so that sound educational movements and methods of rendering such service can be evolved. Unless there is cooperation on the part of educational and professional forces and coordination of their activities, the effects will not meet expectations.

COOPERATION WITH OTHER GROUPS

The Committee on Preventive Medicine and Periodic Health Examinations has held several conferences with members of the Ohio Committee of the American Academy of Pediatrics which is planning a program of postgraduate instruction for general practitioners on the prevention and care of diseases of children. The direct objective of the pediatricians is to bring the subject of general pediatrics in a larger way before the general profession and through it to the people.

The tentative plan of that organization is to have lectures and pediatric roundtable discussions at district or group meetings throughout the state. Such meetings have been held by the pediatricians in several states, notably Illinois, where extraordinary interest was shown by the profession generally.

The chairman of the Ohio Pediatrics Committee sponsoring the proposed programs is Dr. C. W. Burhans, Cleveland, a member of this committee. Three professors of pediatrics, Dr. H. J. Gerstenberger, Cleveland, Dr. A. Graeme Mitchell, Cincinnati, and Dr. E. G. Horton, Co-

lumbus, are aiding in carrying out the plans. The facilities of the State Department of Health have been made available to the committee for statistical help and for publicity. These programs should prove of outstanding educational value to the profession at large and another forward step in the progress of preventive medicine in Ohio.

The Committee on Preventive Medicine and Periodic Health Examinations has been deeply interested in the movement being sponsored by the obstetricians of Ohio for more extensive education of the public as to the value of competent prenatal care. Your committee has been consulted on several occasions on various phases of an educational campaign proposed by the newly-formed Hospital Obstetric Society of Ohio. (See July, 1934, issue *The Journal*, page 459).

The purposes of this society are, briefly: To study, improve and standardize all conditions which concern the welfare of hospitalized pregnant women and the new-born child, including prenatal care, hospital standards, choice of doctor, etc.

Activity of this sort is especially timely since the profession has been criticized in connection with childbirth mortality rates, although authoritative studies of this question reveal that failure of many pregnant women to provide themselves with competent prenatal care is one of the chief causes of maternal mortality and morbidity.

PRENATAL CARE CAMPAIGN SUPPORTED

To assist the obstetricians in getting their program under way, the Committee on Preventive Medicine and Periodic Health Examinations cooperated with Dr. A. J. Skeel, Cleveland, president of the obstetrical group and a member of this committee, and Dr. H. G. Southard, State Director of Health, in the preparation of an article on prenatal care which was released to the press through the local health departments of the state. (See August, 1934, issue *The Journal*, page 537).

Impersonal and accurate publicity from public health authorities on such subjects is good health education procedure. It is hoped that this movement to educate the public concerning prenatal care will tend to bring many more expectant mothers under the observation of physicians before serious conditions have developed. It should become an established custom for every woman at the beginning of pregnancy and periodically until the birth of her child to submit to medical examinations. Statistics show that eclampsia has been enormously reduced by prenatal care and that of the total number of deaths from eclampsia about 90 per cent had seen no physician or had had no prenatal care of any sort previous to the development of convulsions. Prevention here would seem as sensible as the carrying out of the fire hazard code in any community.

VENEREAL DISEASE QUESTION STUDIED

The question of venereal diseases continues to be one of the major public health problems and one deserving the serious consideration of the medical profession and all agencies interested in preventive medicine.

Vital statistics again tell the story. Nearly one-half million new cases of venereal disease are reported every year under treatment. The figure seems incredible yet it has been arrived at from different authentic sources. Since many cases are unreported, there must be, in spite of a large factor of error, an enormous amount of venereal disease. Since 15 per cent of heart mortality and 11 per cent mental disease in the institutions of the country are due to syphilis, the enormity of the preventive opportunity is apparent.

Routine Wassermann tests in connection with health examinations would permit of treatment in many cases before irreparable damage is done in the aorta, central nervous system, or elsewhere. Current literature has been emphasizing the importance of anti-syphilitic treatment during pregnancy because of the remarkable preventability of congenital syphilis. Here is a preventive opportunity long neglected.

It is not intended that there should be interference in the least with moral teachings in regard to personal habits, but on the contrary that they be supported in every way. In making the health examination, the physician has an opportunity to give instructions in prophylaxis. Naturally, the right time and place for giving such advice to the individual before him must be left to the judgment of the physician. Physicians should keep themselves well informed regarding the most improved methods of preventing and treating venereal diseases. Educational procedures are certain to increase the number of persons seeking advice on this subject and the physician must be prepared to render competent service.

To summarize the past year, we are gratified to note that the public as well as the medical profession has not permitted adversity to sidetrack its interest in promoting the preventive aspects of medicine. Popular health education has progressed at a steady pace. This is certain to result in greater demands on the part of the public for personal preventive service from the medical profession. The profession must constantly be preparing itself to meet this increased demand.

ANNUAL REPORT OF THE COMMITTEE ON AUDITING AND APPROPRIATIONS

(Including Jointly the Report of the Treasurer and the Annual Audit)

B. J. HEIN, Chairman.....Toledo
H. V. PARYZEK.....Cleveland
S. J. GOODMAN.....Columbus

During the past year the Ohio State Medical Association, like similar state-wide professional and business organizations, has been confronted with unusual and perplexing financial problems.

Two factors were largely responsible for the difficult situation the Committee on Auditing and Appropriations, charged by The Council with the important task of supervising the financial affairs of the State Association, had to meet during the calendar and fiscal year 1933.

First, the nation-wide economic situation struck a hard blow at the income and resources of the medical profession in general. Naturally, this reacted adversely on the membership of the State Association. Consequently, the income of the State Association from membership dues was somewhat decreased.

Second, business adjustments made under the National Recovery Act, the increase in the prices of commodities, the reduction in the purchasing power of the dollar, and similar economic factors increased the costs of necessary supplies, printing, and equipment for the organization machinery of the State Association, and for the publication of *The Ohio State Medical Journal.* Moreover, the advertising revenue to *The Journal* was substantially reduced from preceding years.

EXPENSES WERE CAREFULLY SCRUTINIZED

Confronted with this serious situation and fully aware of its great responsibilities, the Committee on Auditing and Appropriations, acting on behalf of The Council, set to work to adjust the financial affairs of the State Association so as to keep the State Association on a sound financial basis and, at the same time, make possible the carrying on of organization activities effectively.

The budget for the fiscal and calendar year 1933 submitted by the Committee on Auditing and Appropriations of The Council and approved by it showed a reduction in authorizations for various State Association activities. However, utmost care was used in making adequate provision for financing essential organization functions so that the services of the State Association to the members would not be crippled in any way or the efficiency of the organization machinery lessened.

In cooperation with the Committee on Publications, we succeeded in making an advantageous contract for the printing of *The Journal* during 1933. This neutralized to some extent the loss in advertising revenue.

Great care was exercised by the Committee in supervising expenditures during the year. All bills were carefully checked and examined before vouchers authorizing payment were issued. In fact no bills were contracted except upon previous authorization of the Committee which based its decision upon the necessity for such expenditures.

BUDGETARY ALLOWANCES NOT EXCEEDED

At this time, the Committee on Auditing and Appropriations is pleased to report that because of this careful supervision of the fiscal affairs of the State Association and the efficient management and wholehearted cooperation given us by our state headquarters staff, the State Association during the year 1933 not only kept its expenditures well within the budgetary allowance provided by the Council but was able to accumulate approximately the average yearly balance maintained over a period of the past 16 years to add to our reserve for future emergencies and for extraordinary activities.

It should be remembered that this exceptionally fine record was made during a period of economic uncertainty and confusion and when, because of sudden economic and governmental changes and developments affecting medical practice, it was absolutely necessary to keep our organization machinery running at high speed and in an effective manner. The work of the various committees of the State Association and of the headquarters staff increased in proportion to the increase in the problems confronting organized medicine. Moreover, the multiple details and heavy routine were increased by the prolonged and difficult legislative session. Under ordinary circumstances, the Council undoubtedly would have been justified in adding to our headquarters personnel but on account of the uncertainty and the necessity for economy, the present organization machinery was speeded up to carry the additional load.

Frankly, we are proud of the record the State Association has made in spite of adverse conditions and feel that at present we are in a sounder condition than most other, if not all other, similar organizations. It is especially gratifying to know that our membership has shown a steady increase since the first of the present year in comparison with last year. We have been extremely fortunate that the membership has maintained its interest and has realized

the importance and necessity of a strong, concerted organization.

CONTINUED ECONOMY NECESSARY

Although we have weathered the storm so far in a gratifying way and present indications are that our financial status will be enhanced through increases in membership and in *Journal* advertising revenue, we must bear in mind that the period of uncertainty and sudden changes has not passed. We will continue to follow the sound financial policies that carried us through the past fiscal year. Every precaution and safeguard must be maintained during the ensuing year to protect our resources and minimize our expenditures. There must not be a relaxation in the supervision and management of our fiscal affairs.

The budget for the fiscal and calendar year 1934, submitted to The Council by the Committee on Auditing and Appropriations and adopted by it in December 1933 (January, 1934, issue *The Journal*, pages 42 and 43) is in accord with this policy. It is based on economy and endeavors to harmonize the anticipated revenues and expenditures of the State Association in such a way that we can again add to our accumulated balance.

However, the 1934 budget, we believe, makes ample provision for continuing the machinery of the State Association at a maximum of efficiency and to function to the benefit of the entire membership. All essential and regular activities of the State Association are provided for in the financial layout.

The Council and your committee in formulating the budget for the current year were fully aware of the serious problems confronting the medical profession, resulting from sudden and radical changes in government, the economic confusion, and modifications in the social structure and emphasizing the relatively greater need at present for a strong, harmonious and effective medical organization. We well realized that organization machinery cannot be operated smoothly and effectively unless it is adequately financed. The 1934 budget was drafted with this aim in view. Every effort will be made to keep expenditures within that budget. However, unexpected and serious situations may demand that the State Association undertake additional activities which were not anticipated when the budget was formulated. In that case, we believe authorization of expenditures outside the budgetary limitations will be warranted with the approval of the Council, even if it is necessary to reach into our reserve fund, which is intended to meet emergencies.

In accordance with custom, the Committee on Auditing and Appropriations employed a certified public accountant to audit the records and financial transactions of the State Association and *The Journal* for the last calendar and fiscal year, 1933. The audit is appended to this report. It shows that special attention was given to accurate maintenance of all financial records; the efficient way the business affairs of the State Association were handled, and the constant efforts made to increase the resources of the State Association by investing inactive funds in the soundest interest-bearing bonds and securities.

Accountants' Report Re Ohio State Medical Association at December 31, 1933

Chairman Auditing Committee,
Ohio State Medical Association,
Columbus, Ohio.

Dear Sir:

In accordance with your instructions we have audited the books of the Ohio State Medical Association, for the year ended December 31, 1933 and submit herewith our report, including as a part thereof the following described schedules:

SCHEDULE A—Statement of Cash Receipts and Disbursements for the year ended December 31, 1933.

SCHEDULE B—Statement of Cash and Bonds Reconciliation at December 31, 1933.

AUDIT—All recorded cash was traced to the depository. Disbursements were verified by examination of cancelled checks, supported by vouchers properly approved. Cash on deposit at December 31, 1933, as shown by a certificate from the bank, was reconciled with the balance as shown by the books at that date.

United States Bonds were verified by inspection.

CERTIFICATE—We therefore certify that, in our opinion, subject to the foregoing comments, the statement herein contained correctly states the cash receipts and disbursements of the Ohio State Medical Association for the year ended December 31, 1933.

Respectfully submitted,

KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

SCHEDULE A—STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR THE YEAR ENDED DECEMBER 31, 1933.

Cash on Hand and on Deposit at January 1, 1933		$ 420.52
Certificates of Deposit		12,000.00
United States Bonds		55,000.00
Total Cash and Bonds Jan. 1, 1933		$67,420.52
Receipts		
Membership Dues 1933	$25,766.00	
Annual Meeting	1,525.00	
Interest	3,158.27	
Profit on Exchange of Bonds	369.19	
Total Receipts		30,818.46
Total to be accounted for		$98,238.98
Disbursements		
Ohio State Medical Journal	$ 4,500.00	
Executive Secretary—Salary	6,600.00	

Executive Secretary—Expense	681.89	
Assistant Executive Sec'y—Salary	3,850.00	
Assistant Executive Sec'y—Expense	193.15	
President's Expense	142.77	
Treasurer's Salary	300.00	
Council	634.34	
Annual Meeting	1,060.72	
Auditing	100.00	
Committee on Public Policy	789.25	
Medical Defense	3,319.99	
Miscellaneous Committee Expense	398.70	
Stationery and Supplies	336.19	
Postage and Telegraph	597.18	
Premium on Bonds	205.31	
Moving Expense	117.90	
General Counsel—Salary	2,100.00	
Total Disbursements		$25,936.39
Cash on Hand, on Deposit, and Bonds at December 31, 1933		72,302.59
Total accounted for		$98,238.98

SCHEDULE B—STATEMENT OF CASH AND BOND RECONCILIATION AT DECEMBER 31, 1933.

The Huntington National Bank

Balance as shown by bank statement at December 31, 1933		$ 3,626.85
Add: Deposit in transit at Dec. 31, 1933		766.00
Total		$ 4,392.85
Oustanding Checks		$ 1,090.26
Balance as shown by books at Dec. 31, 1933		$ 3,302.59
Government Bonds:		
U. S. Liberty Bonds 4¼—Registered	$ 5,000.00	
U. S. Treasury Bonds 4¼ and 3¼	20,000.00	
U. S. Treasury Bonds—3⅜	19,000.00	
U. S. Treasury Bonds 3⅜	25,000.00	69,000.00
Total balance as shown by books at Dec. 31, 1933		$72,302.59

Accountants' Report Re Ohio State Medical Journal at December 31, 1933.

To the Committee on Auditing of the
Ohio State Medical Journal,
Columbus, Ohio.

Gentlemen:

In accordance with your instrutcions we have audited the books of the Ohio State Medical Journal, for the year ended December 31, 1933 and submit herewith our report, including as a part thereof the following described schedules:

SCHEDULE A—Balance Sheet at December 31, 1933.

SCHEDULE B—Statement of Revenue and Expense for the year ended December 31, 1933.

Financial Condition

The financial condition of the Ohio State Medical Journal at December 31, 1933 (as shown in detail in Schedule A) was as follows:

Cash on Hand and on Deposit		$ 487.87
Accounts Receivable		712.50
Total Current Assets		$ 1,200.37
Less Current Liabilities		44.75
Net Current Assets		$ 1,155.62
Furniture and Fixtures		2,070.40
Total Net Assets		$ 3,226.02
The above is represented by:		
Surplus		$ 3,226.02

AUDIT—All recorded cash was traced to the depository. Disbursements were verified by examination of cancelled checks, supported by properly approved invoices. Cash on deposit at December 31, 1933, as shown by a certificate from the bank, was reconciled with the balance as shown by the books at that date. Petty cash vouchers were checked and the amount of petty cash on hand was verified by count as of a present date during the audit.

CERTIFICATE—We therefore certify that, in our opinion, subject to the foregoing comments, the statements herein contained correctly state the financial condition of the Ohio State Medical Journal at December 31, 1933, and the Revenue and Expense for the year ended on that date.

Respectfully submitted,

KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

SCHEDULE A—BALANCE SHEET AT DECEMBER 31, 1933.

ASSETS

Current Assets

Cash—The Ohio National Bank	$ 477.87	
Cash—Petty	10.00	
Total Cash		$ 487.87
Accounts Receivable		712.50
Total Current Assets		$ 1,200.37
Property Assets		
Furniture and Fixtures		2,070.40
TOTAL ASSETS		$ 3,270.77

LIABILITIES

Current Liabilities

Subscriptions Prepaid		$ 44.75

SURPLUS

Surplus at December 31, 1932	$ 3,804.68	
Less—Expense in Excess of Revenue for the year ended Dec. 31, 1933	578.66	
Surplus at December 31, 1933		3,226.02
TOTAL LIABILITIES AND SURPLUS		$ 3,270.77

SCHEDULE B—STATEMENT OF REVENUE AND EXPENSE FOR THE YEAR ENDED DECEMBER 31, 1933.

Revenue

Advertising		$ 8,837.00	
Less—Commissions	$808.42		
Cash Discount	252.83	1,061.25	$ 7,775.75
Circulation			4,500.00
Miscellaneous			69.50
Bad Debts Collected			108.00
Total Revenue			$12,453.25

Expense

Journal Printing	$ 6,261.64	
Office Salaries	3,680.00	
Rent	1,500.00	
Journal Postage	408.37	
Telephone and Telegraph	254.26	
Depreciation	195.38	
Bad Debts	37.00	
Journal Envelopes	177.94	
Office Supplies and Expense	137.64	
Stencils and Mimeograph Supplies	37.34	
Dues and Subscriptions	68.18	
Water, Ice and Towel Service	102.35	
News Clipping Service	78.00	
Express and Delivery Service	13.34	
Repairs and Cleaning	21.06	
Halftones and Etchings	15.66	
Miscellaneous Expense	43.75	
Total Expense		13,031.91
Expense in Excess of Revenue for the year ended December 31, 1933		$ 578.66

STATEMENT OF CASH RECONCILIATION AT DECEMBER 31, 1933

The Ohio National Bank

Belance as shown by Bank Statement Dec. 31, 1933		$ 759.42
Less Outstanding Checks		281.55
Balance as shown by Books at Dec. 31, 1933		$ 477.87
Petty Cash		10.00
Total Cash		$ 487.87

ANNUAL REPORT OF THE COMMITTEE ON MILITARY AND VETERANS' AFFAIRS

LOUIS FEID, JR., Chairman.....Cincinnati
JOHN A. SIPHER.....Norwalk
A. J. MCCRACKEN.....Bellefontaine

A year ago the Committee on Military and Veterans' Affairs submitted to the membership of the State Association a detailed account of the significant and important changes brought about early in 1933 in the policy and procedure of the federal government with regard to benefits for ex-service men, including medical care and hospitalization.

As pointed out at that time, the new national policy for dealing with veterans, based on the "Economy Act" enacted by Congress early in 1933 and on executive orders, was in line with the long-established policy of the Ohio State Medical Association and medical organization in general that adequate provision should be made for those ex-service men whose physical disabilities were incurred in or resulted from military or naval service and for the dependents of those who died in the service, but that compensation should not be paid to and medical and hospital service provided at the expense of the federal government for those whose disabilities were not incurred in or the result of military or naval service.

It will be recalled that reference was made to the new regulations which took from the pension roll many non-service cases, provided more equitable benefits for deserving veterans, limited medical care and hospitalization to veterans suffering from service-connected disabilities, and halted the construction of additional government hospitals for the care of ex-service men.

During the past year and since the 1933 report of the Committee on Military and Veterans' Affairs was submitted to the membership, important events directly affecting the veterans' program of the federal government have taken place. The 1933 regulations governing veterans' benefits have been modified and changed, reviving serious problems that had been temporarily solved and creating new ones of equal seriousness.

As expected, the regulations promulgated by executive orders in the summer of 1933 were protested by many ex-service men who lost government benefits through the new regulations and by some of the veterans' organizations. Campaigns for the restoration of the old benefits were launched and the question quickly became a political issue of great significance.

Congress convening in regular session was swamped with measures seeking the restoration of most of the benefits withdrawn from ex-service men by the executive regulations. One of the principal measures Congress was called upon to consider was that relating to hospitalization of veterans and which in effect provides free hospitalization for any honorably-discharged ex-service man irrespective of the origin of his disability.

In March, 1934, an amendment in line with this unlimited hospitalization privilege was appended to the Independent Offices Appropriation Bill. The amendment carried the following proviso:

"Provided, that any veteran of any war who was not dishonorably discharged, suffering from disability, disease, or defect, who is in need of hospitalization or domiciliary care, and is unable to defray the necessary expense therefor (including transportation to and from Veterans' Administration facility), shall be furnished necessary hospitalization or domiciliary care (including transportation) in any Veterans' Administration facility, within the limits existing in such facilities, irrespective of whether the disability, disease, or defect was due to service. The statement under oath of the applicant on such form as may be prescribed by the Administrator of Veterans' Affairs shall be accepted as sufficient evidence of inability to defray necessary expenses."

The hospitalization amendment became a law on March 28, 1934, when the appropriation measure of which it was a part was passed by both houses of Congress over the President's veto.

The new law relating to hospital privileges for veterans makes a part of the statutes certain provisions already granted by executive order and broadens the scope and limitations of the hospitalization privileges of the veterans' program. Although it limits hospitalization to those who are willing to make oath as to their inability to pay for medical and hospital care, it goes beyond anything heretofore contemplated in that it provides for free care for nonservice-connected disability. Under the World War Veterans' Act of 1924, hospitalization of cases of non-service-connected disabilities was discretionary with the Administrator of Veterans' Affairs. Under the executive orders supplanting the act of 1924, hospitalization was limited to veterans suffering from service-connected disabilities or any veteran in need of emergency hospital treatment, but discretion in the matter was left to the head of the Veterans' Administration.

The danger in this new hospitalization provision now on the statutes was referred to in the recent report of the Committee on Legislative Activities of the American Medical Association to the House of Delegates of the A.M.A. at the Cleveland meeting. To quote:

"We hope that the Veterans' Bureau will be

able to resist prescribing a form which would liberalize the amended law beyond interpreting the oath to mean that the veteran is in actual need. We certainly must see that the regulations will make it extremely difficult for a veteran to accept charity when he is able to pay something to his home doctor and community hospital for services required. We should oppose a loose construction of law which would enable a veteran to escape his civic responsibility.

"Can we not assume that the majority of veterans will agree with the citizenship generally that this law should be interpreted for the needy and that an oath to the contrary should not be regarded lightly?

"For the present there has been no effort to bring about increased hospital facilities, and without an increase of such facilities the evil effect on the profession will lessen, because many of these hospitals will be diverted into domiciliary homes.

"On the other hand, if the oath required by the law, wherein the veteran swears his inability to defray necessary expenses, is treated lightly we shall then be confronted with a serious situation."

In view of these developments, the Committee on Military and Veterans' Affairs can arrive at but one conclusion, and that is:

One of the most serious and difficult questions still confronting the medical profession and organized medicine, demanding judicious, courageous and concerted activity on the part of organized medicine, is that arising from the medical and hospitalization phases of the federal veterans' program.

It is our belief that many members of the medical profession have failed to grasp the significance of and to realize the inherent evils and potential dangers of the gigantic medical and hospital system that has been built up over a period of years as a part of the veterans' program.

Based on principles and policies that violate in many respects sound economic, social and medical concepts and with a record of grave abuses, inequalities and injustices, the program exemplifies the dangers and evils of socialized and government-controlled medicine. Moreover, it can easily become the nucleus for an even greater system that would provide medical and hospital benefits for other, or all, groups of society.

For this reason, it is imperative that the medical profession do everything within its power to keep the veterans' program within proper limitations and so far as possible in line with sound medical, social and economic principles. The influence and strength of organized medicine must be used to create public sentiment against those trying to use the veterans' program for political and selfish purposes.

It is the duty of medical organization in every community to seek the cooperation of veterans' organization and to submit to them the opinions of the profession, asking that they aid in protecting the rights of the profession which is sincerely interested in seeing that the deserving ex-service man receives every possible consideration but is unwilling to submit to a program designed for the undeserving and which will be morally and financially destructive to the nation and disastrous to the medical profession and the voluntary hospitals of the country.

STRONG MEDICAL RESERVE CORPS IMPORTANT

Being a contact unit between the medical profession of Ohio and the medical departments of the Regular Army and the Ohio National Guard, the Committee on Military and Veterans' Affairs has cooperated in stimulating enlistments in the Organized Medical Reserve Corps and in other activities designed to provide adequately and competently manned medical units for the army.

Your committee urges the medical profession to maintain its interest in military affairs. Enlistment in the Officers' Reserve Corps gives a physician the training and experience that will make him a more valuable cog in the military machine and enhance his chances for high rank in case of a national emergency. A considerable number of physicians are members of the Ohio National Guard, attending the annual encampment of the various guard units where they receive valuable and practical training in handling troops.

Under the present War Department mobilization plan, 17 medical department reserve units in Ohio are designated for mobilization on M-Day, or the day of mobilization. This number does not include National Guard or Reserve Units and detachments assigned to divisions or line troops. These units are classed as Non-Divisional Medical Department Units and Regular Army Inactive Units.

The distribution of the units throughout the state is as follows: Cleveland 8, Columbus 4, Cincinnati 3, and Toledo 2. As far as practicable, the personnel for the various units is drawn from the city and vicinity in which they are located.

Each year all graduates of the medical schools in the state are invited to join the Reserve Corps when they have successfully passed the State Board Examination. Promotion is now made upon a certificate of capacity for promotion. This certificate may be earned by taking a written examination in certain specified military subjects or satisfactory completion of such subjects in the Army Extension School and a practical test, the successful completion of which establishes the officer's eligibility for promotion when he has served sufficient time in grade and a vacancy occurs.

Army extension courses which cover a number of military subjects which would confront the citizen officer upon assuming his duties as an officer in the time of emergency are available to all Medical Reserve Officers.

The object of the extension school is to fit the Reserve Officer who finds that he does not have time to devote to active duty training in peace time for the duties which would confront him in the time of war. On December 31, 1933, 370 Medical Department Reserve Officers, residents of the State of Ohio, were enrolled in the extension school. This represents an increase of 60 students over the preceeding year.

Under the provisions of the National Defense Act as amended by the Act of June 15, 1933, commissions of officers who are on a dual status, members of the Officers Reserve Corps and the National Guard, are being terminated. These officers are being commissioned in the National Guard of the United States in the same arm or service and the same grade.

Appointments in the medical units of the Organized Reserve Corps of Ohio showed a substantial increase during 1933. However, the procurement quota for the Fifth Corps Area, comprising Ohio, Indiana, Kentucky and West Virginia, has not been attained and there still are vacancies in every branch of the medical department except the Sanitary and Dental Reserve Corps.

The following figures furnished by Colonel David Baker, Fifth Corps Area Surgeon, Fort Hayes, Columbus, show the distribution of Ohioans enrolled in the medical units and groups of the Officers Reserve Corps at the end of 1933 and, for comparison, 1932:

ACTIVE, CORPS AREA ASSIGNMENT GROUP
(Under Corps Area Commander)

Branch	Colonel	Lt. Col.	Major	Captain	1st Lt.	2nd Lt.	Total 1933	1932
Medical	16	44	62	62	531	0	715	542
Dental	0	3	22	37	317	0	379	346
Sanitary	0	0	1	3	5	3	12	15
Veterinary	0	1	4	2	8	72	87	67
Med. Adm.	0	0	0	8	20	47	75	75
Totals	16	48	89	112	881	122	1268	1045

INACTIVE, CORPS AREA ASSIGNMENT GROUP
(Under Corps Area Commander)

Medical	0	0	9	12	86	0	107	141
Dental	0	0	2	8	36	0	46	67
Sanitary	0	0	0	1	0	0	1	0
Veterinary	0	0	0	2	1	4	7	13
Med. Adm.	0	0	0	0	2	13	15	18
Totals	0	0	11	23	125	17	176	239

ACTIVE, ARM AND SERVICE ASSIGNMENT GROUP
(Under Chief of Branch)

Medical	0	0	1	5	10	0	16	17
Dental	0	0	0	2	2	0	4	4
Sanitary	0	0	4	3	0	1	8	10
Veterinary	0	0	1	2	0	0	3	2
Med. Adm.	0	0	0	0	1	1	2	2
Totals	0	0	6	12	13	2	33	35

INACTIVE, ARM AND SERVICE ASSIGNMENT GROUP
(Under Chief of Branch)

Medical	0	0	1	1	5	0	7	10
Dental	0	0	0	0	1	0	1	2
Sanitary	0	0	0	0	0	0	0	2
Veterinary	0	0	0	1	0	0	1	3
Med. Adm.	0	0	0	1	1	0	2	2
Totals	0	0	1	3	7	0	11	19

NEW APPOINTMENTS

Medical	Dental	Sanitary	Vet.	Med. Adm.	Total '33	'32
140	32	0	12	8	192	161

PROMOTIONS

Medical	Dental	Sanitary	Vet.	Med. Adm.	Total '33	'32
15	11	2	0	3	31	22

— OSMJ —

Lima Lecture Program Announced

The following lectures will be given by Dr. Arthur E. Hertzler, University of Kansas, at the Annual Post Graduate Lecture Course of the Academy of Medicine of Lima and Allen County, October 8 to 12 inclusive, 4:30 p. m. to 5:30 p. m. and 6:30 p. m. to 7:30 p. m. daily at the Eagles Hall, Lima:

"Brain Injuries, Diagnosis and Treatment."

"Diseases of the Thyroid Gland, Diagnosis and Treatment."

"Diseases of the Pleura, Diagnosis and Treatment."

"Gastric Ulcer and Gastric Cancer, Diagnosis and Treatment."

"Gall Bladder Disease, Pathology, Diagnosis and Treatment."

"Management of Appendicitis."

"Acute Pancreatitis, Diagnosis and Treatment."

"Female Pelvis, Indications for Surgery."

"Surgery of the Blood Vessels of the Lower Extremities: Varicose Veins, Buerger's Disease, Reynaud's Disease, Leg Ulcers and Gangrene."

"Rectal Diseases, Diagnosis and Treatment."

"Bone Infections."

— OSMJ —

—Painting of the Alliance City Hospital at a cost of $8,362 was one of the FERA projects recently approved by the State Relief Commission.

—Mrs. Dorothy N. Miller, Mechanicsburg and formerly connected with the Springfield City Hospital, has been named superintendent of the Wilson Memorial Hospital, Sidney, succeeding Mrs. Elizabeth Woolson, resigned to become head of Christian Hospital, St. Louis.

—Remodeling of the clubhouse at the Defiance Golf Club for occupancy by the Defiance Hospital Association is proceeding rapidly.

—Contracts have been awarded for construction of a new wing to the Martins Ferry Hospital.

ANNUAL REPORT OF THE COUNCILORS

Submitted by James A. Beer, M.D., Secretary of Council

A detailed review of the official activities of the Council during the past year is unnecessary since they have for the most part been summarized in the minutes of the meetings of the Council, published in the October, 1933, December, 1933, January, 1934, April, 1934, June, 1934, and August, 1934, issues of *The Ohio State Medical Journal.*

The records of these meetings clearly indicate that the Council has completed a year of unprecedented activity; been called upon to consider an unusually large number of difficult and complex problems, and that the individual members of the Council have given much time and effort in their official capacity to directing the activities of the State Association.

In all its transactions and activities, the Council has endeavored to be consistent, unbiased and sympathetic. It has devoted careful study to each and every question before it. It has consistently tried to serve the best interests of the medical profession as a whole. In arriving at conclusions and formulating procedure, it has used as a basis the principles and policies laid down by the House of Delegates from time to time and what it believed to be the sentiment of the majority of the membership.

We believe it appropriate in this report to consider and make a few observations on some of the conditions affecting medicine and medical practice and some of the vital questions organized medicine will be called upon to face during the ensuing twelve months. Undoubtedly, the membership is quite familiar with most, if not all, of them, but reemphasis, we believe, will serve as a stimulant to concerted action.

Two things should be kept constantly in mind during the ensuing year:

First, past developments and present trends indicate that the forthcoming months will witness the most determined drive ever staged in this country for wholesale changes in our economic and social relationships having a direct and revolutionary effect on the practice of medicine and the relationship between physician and patient.

Second, the need for strong, active and harmonious medical organization and concerted action by physicians as individuals will be relatively greater during the ensuing year than ever before because of critical situations that have already arrived or are in the making.

We must frankly recognize that major social, economic and governmental changes and developments which have taken place, are now in progress, or under consideration, have had or will have an immediate and important effect on our entire system of medical service. As has been pointed out by more than one observer, there is now under way an experimentation in collectivism unequalled in its social significance in all history. Well-organized and influential groups are determined that medicine shall be included in this gigantic social experiment and are at work to bring about the absolute socialization of medicine either by legislative enactment, by governmental manifesto, or both.

Traditional and normal relationships, not only in medicine but in all fields of activity, have been suddenly and radically changed. If present plans and programs materialize, even greater and more radical changes will result. Public sentiment is in a state of confusion and uncertainty. The public's views toward governmental supervision, regulation and regimentation have been modified to a startling degree during recent years. Although there are indications of increasing dissatisfaction with super-direction and control by a select few, there is still a large portion of the population which favors centralization and extension of the functions of government on a permanent basis along the lines of the temporary programs developed to meet the critical conditions incident to the depression and social unrest.

With this in mind, organized medicine should realize that the problems of the past will be in a sense insignificant in comparison to those it undoubtedly will be called upon to face in the immediate future.

How best to meet the many serious questions we now have before us and those anticipated is a matter which should command the attention of every thinking member of the medical profession. Many of these questions are of national or statewide importance. Others are local in scope and effect. The establishment of some one plan or program so designed that it would bring about the solution of all sorts of local problems and so set up that it would be able to anticipate questions likely to arise in the future has been suggested. This would be impracticable and impossible. Economic conditions, social tendencies, public demands, and scores of other situations vary in different communities and must be considered distinctly and separately by each community. The mechanics for handling most of the problems confronting the medical profession must be patterned to meet local conditions and must be operated locally.

However, when it comes to the matter of policies and principles, the extent or scope of a question cuts little figure. Fundamental principles and policies which should determine the attitude and position of the medical profession on

questions of direct import can be applied in any and all cases. Such principles and policies do exist; are sufficiently clear in their general intent; and are broad enough to cover every situation likely to arise.

The Council again emphasizes the importance of creating in each county medical society and academy of medicine a committee on public relations, civics, or economics to thoroughly study all public questions in any way affecting medical practice and to maintain effective contacts with public officials and all groups or agencies interested in such qnestions, in order that the policy and attitude of the medical profession may be effectively presented.

As we survey the future, we are more convinced than ever before that the future of medicine depends to a large degree on the unity and aggressiveness of medical organization. As long as the medical profession maintains an organization of such character there is some assurance that the integrity of scientific medicine can be preserved and a system of medical service developed in line with principles which will protect the character of the service and keep medicine on a professional basis. It is safe to predict that little consideration will be given to the medical profession and its viewpoint unless it is actively represented by an aggressive, united and efficient organization.

The value of a strong and aggressive organization to the profession has been demonstrated repeatedly during the past year. Because the profession was effectively represented by organized medicine, many difficulties were satisfactorily solved and others loaded with potential danger were forestalled. The results attained were not the work of a few but of the membership in general, working together, backing up the leadership, and rallying for concerted activity when the occasion demanded.

Some members have the mistaken idea that it is the business and function of the Council to take the initiative in handling local problems. Local situations can best be met through the local county medical society, basing its activities and position on such matters on the principles and policies promulgated by the House of Delegates or the Council.

Of course, the Council always has been and always will be willing and anxious to assist physicians in every community with their local problems. During the past year, numerous local questions have been presented to the Council for consideration and in every case advice as to procedure has been offered by the Council after deliberate consideration by it or by one of the standing or special committees of the State Association.

Ethical, constitutional and professional relation questions were referred for study and report to a special Judicial Committee of the Council, consisting of Dr. H. M. Platter, chairman, Dr. John A. Caldwell and Dr. I. P. Seiler. By reference made here the activities of that committee, published in the *Council* minutes are a part of this report.

It is also appropriate in this report to compliment and express appreciation to our efficient Executive Secretary and his faithful assistants for handling the myriad and constantly increasing details in our headquarters office.

To re-emphasize what has been said repeatedly, the basic element in medical organization is the county medical society. Without the support and active cooperation of the various county medical societies and academies of medicine, state and national medical organizations cannot function effectively. Unless the medical profession of each community is represented by a strong and active county medical society, local questions of direct interest to the profession will not receive the consideration they should have and the influence of the profession in civic and governmental matters will be negligible. Unless each county medical society has the wholehearted support and active interest of every eligible physician in the community, it will be handicapped in meeting all its obligations. Strong leadership should be provided each county society. As many members as possible and practicable should be given some part to play in the activities of the society. Committeemen should be selected with care and efforts made to formulate programs that will attract the membership to society meetings and develop sustained interest. Effective public relations should be established and all members urged to take an active interest as individuals in civic and political affairs.

The members of the Council are eager at all times to assist the societies of their respective districts in these matters. The Council as a whole is vitally interested in the activities and problems of the various county societies, has assisted them on many occasions and will continue to do so. Officers of the county societies should feel free to consult with members of the Council frequently. Close contact between each county society and its Councilor is essential to efficient organization procedure.

Each Councilor endeavors to visit each society in his district several times during the year. He should be kept informed concerning meeting dates and the activities of each society in his district. County society officers should plan to have him discuss with them and the membership questions of direct interest to the profession as a whole. This has the effect of keeping the various county societies well-informed on activities of the State Association and the Councilor himself in touch with the problems of the local societies.

Appended to this report is a summary of the membership figures of the various county societies and academies of medicine, divided by districts. It is gratifying to note that the total membership in the State Association has shown a substantial increase compared to a year ago. Many societies have registered considerable increases and quite a few include practically every eligible physician within their jurisdiction. A few societies are not as strong in point of numbers as they should be. Special effort on the part of the officers of these societies should remedy this situation. Such action should be taken promptly for during the coming year medical organization will need all the numerical strength it can possibly master.

The machinery of medical organization must be operated at high speed during the forthcoming months. This can be done if every county society and academy of medicine tunes its activities to a high pitch, every eligible physician is enrolled, and each member gives his enthusiastic and active support to the activities of organized medicine, both local and state.

COUNCILOR ANNUAL REPORT
MEMBERSHIP DATA

First District

Parke G. Smith, M.D., Councilor, Cincinnati

County	Paid Membership 1933	to 9-10-34
Adams	15	15
Brown	6	5
Butler	67	71
Clermont	20	21
Clinton	23	24
Fayette	16	14
Hamilton	545	593
Highland	18	21
Warren	18	22
	728	786

Second District

E. M. Huston, M. D., Councilor, Dayton

Champaign	20	20
Clark	68	71
Darke	32	32
Greene	31	33
Miami	49	51
Montgomery	256	270
Preble	15	17
Shelby	23	20
	494	514

Third District

O. P. Klotz, M.D., Councilor, Findlay

Allen	76	66
Auglaize	27	29
Hancock	37	41
Hardin	22	23
Logan	25	23
Marion	36	39
Mercer	14	16
Seneca	39	30
Van Wert	23	21
Wyandot	11	13
	310	301

Fourth District

B. J. Hein, M.D., Councilor, Toledo

Defiance	16	18
Fulton	18	16
Henry	14	14
Lucas	241	237
Ottawa	13	11
Paulding	11	12
Putnam	25	25
Sandusky	29	33
Williams	16	17
	418	418

Fifth District

H. V. Paryzek, M.D., Councilor, Cleveland

Ashtabula	40	41
Cuyahoga	975	920
Erie	31	33
Geauga	10	9
Huron	19	20
Lake	18	22
Lorain	95	102
Medina	21	21
Trumbull	50	42
	1259	1210

Sixth District

H. S. Davidson, M.D., Councilor, Akron

Ashland	18	21
Holmes	7	9
Mahoning	194	195
Portage	27	27
Richland	56	58
Stark	168	178
Summit	250	257
Wayne	48	41
	768	786

Seventh District

E. B. Shanley, M.D., Councilor, New Philadelphia

Belmont	49	50
Carroll	(with Stark Co. Soc.)	
Columbiana	51	50
Coshocton	20	25
Harrison	7	10
Jefferson	44	50
Monroe	10	7
Tuscarawas	47	46
	228	238

Eighth District

E. R. Brush, M.D., Councilor, Zanesville

Athens	35	38
Fairfield	33	36
Guernsey	30	32
Licking	45	49
Morgan	10	12

County	Paid Membership 1933	to 9-10-34
Muskingum	49	49
Noble	1	1
Perry	19	19
Washington	36	42
	258	278

Ninth District

I. P. Seiler, M.D., Councilor, Piketon

Gallia	23	22
Hocking	13	14
Jackson	12	12
Lawrence	16	20
Meigs	13	14
Pike	6	7
Scioto	71	68
Vinton	3	5
	157	162

Tenth District

S. J. Goodman, M.D., Councilor, Columbus

Crawford	28	28
Delaware	23	23
Franklin	407	384
Knox	25	26
Madison	12	12
Morrow	7	10
Pickaway	11	14
Ross	38	38
Union	16	17
	567	552
Grand Total	5187	5245

— OSMJ —

Mt. Victory—Dr. Robert H. Zeis, formerly of Kenton, has moved here and opened offices for private practice.

— OSMJ —

A letter received by the State Headquarters Office from Dr. A. T. McCormack, secretary of the Kentucky State Medical Association, extends on behalf of the president of that association, Dr. C. C. Howard, an invitation to the members of the Ohio State Medical Association to attend the 1934 annual meeting of the Kentucky association at Harlan, Kentucky, Monday, Tuesday, Wednesday and Thursday, October 1, 2, 3 and 4, and take part in the discussions.

— OSMJ —

—The following new resident physicians and interns for the ensuing year have been announced by Good Samaritan Hospital, Cincinnati: Resident physicians: Dr. Ralph E. Hatfield, Norwood, and Dr. Charles H. Moore, Dr. L. Courtney Jack, Dr. Louis P. Stickley and Dr. Edward J. Bender of Cincinnati.

Interns: Dr. Harold N. Cavannaugh, Reading, Ohio; Harry R. Dougherty, Walton, Ky.; Bruce R. Powers, Knoxville, Tenn., and Drs. Michael Ryan Barrett, Herbert J. Brinker, August F. Fath, Richard B. Homan, Robert E. Khoun, J. Philip Owens, Charles Sonneman and G. Howard Wood of Cincinnati.

Deaths in Ohio

Benjamin H. Blair, M.D., Lebanon; Louisville Medical College, Louisville, Kentucky, 1876; aged 79; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 15 of heart disease. Dr. Blair located in Lebanon in 1888 and was a leader in the professional and civic life of the community. He was a former president of the board of education; member of the Presbyterian Church, and affiliated with the Odd Fellows and Knights of Pythias lodges. He leaves two sons, Dr. Edward and Dr. Robert M. Blair, Lebanon; one daughter and one brother.

Joseph W. Forshey, M.D., Lowell; Starling Medical College, Columbus, 1903; aged 64; member of the Ohio State Medical Association and of the American Medical Association; died August 16. Dr. Forshey had practiced for many years in Morgan and Washington counties, retiring in June because of his health. He was a member of the Masonic Lodge. Surviving are his widow and three daughters.

William N. Gilmore, M.D., East Liverpool· Western Reserve University, School of Medicine, Cleveland, 1882; aged 76; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 29 following an extended illness. Dr. Gilmore practiced for many years at West Point before locating in East Liverpool. Surviving are his widow, one son, one brother and one sister.

Jonathan A. Kackley, M.D., Pleasant City; Columbus Medical College, Columbus, 1882; aged 77; died August 23 of heart disease. Dr. Kackley was an elder of the Lutheran Church and a member of the Masonic and Pythian lodges. Surviving are his widow, two sons, Dr. Ellis Kackley, Adena, and Dr. Roy Kackley, Galion; two daughters and one sister.

Frederick Kenan, M.D., Upper Sandusky; Starling Medical College, Columbus, 1906; aged 59; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 8 of heart disease. Dr. Kenan was a native of Upper Sandusky. His widow, one son, his mother and one brother survive.

Charles W. King, M.D., Dayton; Medical College of Ohio, Cincinnati, 1878; aged 80; member of the Ohio State Medical Association and the American Medical Association; died August 23 following a prolonged illness. Dr. King located in Dayton in 1883 when he was appointed super-

intendent of the Dayton State Hospital. He served for eight years, resigning to enter private practice. He retired three years ago. Dr. King belonged to the Masonic Lodge and the Dayton City Club. His widow, one brother and two sisters survive.

George Willard Mehl, M.D., Ashland; Ohio Medical University, Columbus, 1904; aged 68; member of the Ohio State Medical Association and the American Medical Association; died August 29 of heart disease. Dr. Mehl was born in Germany, coming to America at the age of 15 years. Dr. Mehl was a veteran of the Spanish-American War. He was a member of the Methodist Episcopal Church, Masonic and Moose lodges, and the United Spanish War Veterans. He served as health commissioner of Ashland in 1924 and 1925 and was appointed to that office last January, resigning because of his health. His widow, one son and one daughter survive.

Van Buren McConnaughey, M.D., Hillsboro; Ohio Medical University, Columbus, 1893; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died August 28 of paralysis. Dr. McConnaughey practiced at Perryville before moving to Hillsboro in 1898. His widow, one son and one daughter survive.

John R. Parry, M.D., Woodsfield; Medical College of Ohio, Cincinnati, 1878; aged 79; former member of the Ohio State Medical Association and a former Fellow of the American Medical Association; died August 29. He had practiced for many years in Monroe County and was a medical examiner for the U. S. Pension Board. His widow, two sons and one daughter survive.

John A. Podsedly, M.D., Cleveland; St. Louis Medical School, 1926; aged 34; member of the Ohio State Medical Association and the American Medical Association; died August 9. Dr. Podsedly was a member of the visiting staff at St. Ann's Hospital. Surviving are his widow, one son and two daughters.

Charles Alexander Shaeffer, M.D., Lees Creek; Baltimore Medical College, Baltimore, Md., 1893; aged 67; died August 17 of cancer. His widow, one daughter and two sons survive.

Ralph W. Staley, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 29 of heart disease. Dr. Staley was a member of the faculty, urological department, University of Cincinnati, College of Medicine, and a member of the staffs of the Cincinnati General Hospital and St. Mary Hospital. He was a World War veteran, having served as a member of a base hospital operating staff in France. Dr. Staley held membership in the American Urological Association. He was a native of Sidney. Surviving are his widow and one daughter.

James T. Suggs, M.D., Cleveland; Howard University, College of Medicine, 1903; aged 57; former member of the Ohio State Medical Association and the American Medical Association; died August 20. He had practiced in Cleveland for 20 years. His widow and one sister survive.

Leonidas F. Towers, M.D., Toledo; Physio-Medical College of Indiana, Indianapolis, 1880; aged 74; died August 13. Dr. Towers was a former member of the State Medical Board, president and organizer of the Dime Savings Bank and Trust Co., Toledo, an organizer of the Toledo Automobile Club and a member of the Masonic Lodge. His widow and two daughters survive.

Alfred T. Wright, M.D., Waynesville; Jefferson Medical College, Philadelphia, 1876; aged 81; former member of the Ohio State Medical Association and the American Medical Association; died August 15 following an extended illness. He leaves two sons and four sisters.

— OSMJ —

Program for Northwestern Ohio Meeting October 2 at Toledo

Ninetieth annual meeting of the Northwestern Ohio Medical Association will be held Tuesday, October 2, at the Academy of Medicine Building, Monroe and 15th Streets, Toledo.

The following program has been arranged for the meeting:

9:30 to 10 a. m.—Business session and election of officers.

10 a. m. to 10:45 a. m.—"Principles and Practices in the Management of Patients with Allergy", Dr. Milton B. Cohen, Cleveland.

10:45 a. m. to 11:30 a. m.—"Newer Developments in the Diagnosis and Treatment of Some Diseases of the Blood Forming Organs", Dr. Raphael Isaacs, associate professor of internal medicine, University of Michigan.

11:30 a. m. to 12:15 p. m.—"Diagnosis of Malignancy", Dr. Douglas Quick, New York City.

12:15 p. m. to 1:30 p. m.—Luncheon.

1:30 p. m. to 2:15 p. m.—"Diagnosis of Tuberculosis in Infancy and in Grade School Age", Dr. Frederic M. McPhedran, associate professor of medicine, University of Pennsylvania.

2:15 p. m. to 3 p. m.—"Head Injuries", Dr. A. R. Morrow, Chicago.

3 p. m. to 3:45 p. m.—"Treatment of Malignancy", Dr. Douglas Quick, New York City.

3:45 p. m. to 4:30 p. m.—"Diagnosis of Tuberculosis in Adolescence and in Adult Life", Dr. Frederic M. McPhedran, University of Pennsylvania.

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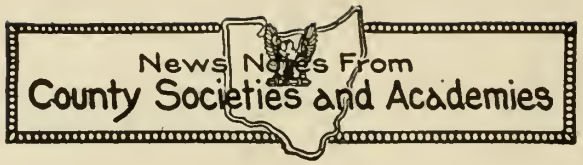
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FOR ALKALIZATION



First District

Fayette County Medical Society resumed its Fall activities on September 6 with a luncheon at the Cherry Hotel, Washington C. H. The guest speakers were Dr. Charles E. Turner, Columbus, who spoke on "Obstetrical Hemorrhages" and Dr. R. W. Lukens, Hillsboro, who read a paper on "Early Diagnosis of Pregnancy".—James F. Wilson, M.D., secretary.

Warren County Medical Society met in regular session September 4 at Harmon Hall, Lebanon. Dr. James Pearce, Cincinnati, was the guest speaker.—News clipping.

Second District

Darke County Medical Society opened its Fall activities with a dinner meeting September 21 at the Greenville Country Club. The guest speaker was Dr. Charles P. Emerson, University of Indiana.—W. D. Bishop, M.D., secretary.

Greene County Medical Society met September 6 at Xenia. Dr. R. R. McClellan, Xenia, presented an interesting report on the results of treatment of 50 cases of hip fracture. A luncheon was served following the meeting.—Harold E. Ray, M.D., secretary.

Miami County Medical Society met on September 7 at the Stouder Memorial Hospital, Troy. A paper, "The Maggot Treatment of Suppurating Wounds and Osteomyelitis", was read by Dr. W. W. Weis, Piqua. The discussion was opened by Dr. G. E. McCullough, Troy. Dinner was served following the program.—Bulletin.

Third District

Hancock County Medical Society had two Detroit physicians, Dr. William Gordon and Dr. Grover Penberthy, as guest speakers at its meeting September 6 at the Elks' Club, Findlay. Dr. Gordon spoke on "Fetal Hypoglycemia Due to Hyperinsulinism". A paper on "General Treatment of Burns" was presented by Dr. Penberthy who also showed motion pictures on "Tannic Acid Treatment of Burns".—H. O. Crosby, M.D., secretary.

Logan County Medical Society in session September 7 at Bellefontaine was addressed by Dr. W. D. Inglis, Columbus. The subject of his address was "Making Childbirth Safer for Mother and Child".—News clipping.

Marion County—The first Fall meeting of the Marion Academy of Medicine was held September 4 at the Marion City Hospital. The program was opened with a historical sketch, "William Harvey —The Circulation of the Blood", by Dr. C. L. Baker. Dr. J. W. Bull presented a case history. The guest speaker was Dr. Roy W. Scott, professor of clinical medicine, Western Reserve University. He spoke on "The Problems of Heart Disease from the Practitioners' Standpoint", using lantern slides to illustrate the major points of his address. Many guests from Wyandot, Morrow, Delaware and Union counties were present. —J. W. Jolley, M.D., secretary.

Fourth District

Putnam County Medical Society met at Pandora on September 4 with Dr. R. E. Bushong, Lima, as guest speaker. He spoke on "Mental Diseases".—News clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

September 21—General session. Program: "New Conceptions of the Diagnosis and Treatment of the Urinary Tract Infections", Dr. Hugh Cabot, Rochester, Minnesota.

Huron County Medical Society was addressed by Dr. W. N. Taylor, Columbus, at its regular meeting August 15 at the Willard Municipal Hospital.—News clipping.

Lorain County Medical Society resumed its Fall activities with a dinner meeting September 11 at the Second Congregational Church, Elyria. The program consisted of "A Book Review—In Honor of Dr. E. E. Sheffield", by Dr. W. E. Hart, secretary of the society.—Bulletin.

Sixth District

Mahoning County Medical Society sponsored a series of eight lectures on "Recent Advances in Applied Physiology" during the month of September. The guest lecturer was Dr. Carl J. Wiggers, professor of physiology, Western Reserve University. The following lectures were presented: The Regulation of Motor Functions of the Gastro-Intestinal Tract; The Physiological Interpretation of Gastro-Intestinal Disturbances; The Functions of the Liver; Normal and Abnormal Mechanisms of Cardiac Rhythm; The Control of the Coronary Circulation; The Physiological Consequences of Coronary Occlusion; The Value and Limitations of the Electrocardiogram in Diagnosis, and The Mechanisms of Cardiac Compensation and Decompensation.—Bulletin.

Portage County Medical Society met September 6 at the Robinson Memorial Hospital, Ravenna. Dr. Bernard H. Nichols, Cleveland, addressed the

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society on "Use of Dense Media in the Making of *X*-ray Pictures", showing exhibits to illustrate his points. Dr. R. D. Worden, county health commissioner, discussed cases of tropical malaria reported in Aurora.—Bulletin.

Stark County Medical Society met in regular session at the Courtland Hotel on September 11. An address on "Management of Fractures" was delivered by Dr. Maxwell Harbin, Cleveland. The discussion was opened by Dr. Kay Liber.—Bulletin.

Summit County Medical Society met September 4 at the Mayflower Hotel. The guest speaker was Dr. C. R. G. Forrester, Chicago, who spoke on "Reduction of Acute Fractures Under Local Anesthesia Together with Ambulatory Aftercare". He illustrated his talk with motion pictures and exhibited splints which he uses in his practice.—Bulletin.

Wayne County Medical Society met on September 11 at Hygeia Hall, Wooster. An interesting talk on his observations in England, Germany, France and Switzerland was made by Dr. W. G. Rhoten, county health commissioner, who recently returned from Europe. Report on a case of Rocky Mountain spotted fever in a resident of Wayne County who had spent his vacation in the West was discussed. The society commended the work of the Committee on Public Policy and Public Health in editing articles being distributed to the local newspapers under the sponsorship of the society.

The annual summer outing of the society was held on August 14 at the Institution for Feeble Minded, Apple Creek with Dr. and Mrs. L. W. Yule and Dr. Kimber as hosts and hostess. The dentists of the county and their wives were guests. A picnic dinner was served in the oak grove and a program of entertainment and recreation for all was enjoyed.—R. C. Paul, M.D., secretary.

Seventh District

Belmont County Medical Society opened its Fall activities on September 6 with a meeting at the First National Bank Building, Bellaire. The guest speaker was Dr. C. S. Bickel, Wheeling, West Va., who spoke on "Toxemia of Pregnancy".—News clipping.

Tuscarawas County Medical Society met September 13 at Uhrichsville. Dr. Carl Koehler, Cincinnati, was the guest speaker. He spoke on "*X*-ray Consideration of Gall Bladder Diseases", using lantern slides to illustrate his paper.—Bulletin.

Eighth District

Athens County Medical Society was entertained on September 10 at the home of Dr. T. A. Copeland, secretary, near Stewart. The guest speaker was Dr. George T. Harding, III, Columbus, who

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Chairman Program Committee, Dr. George Crile, Managing-Director, Dr. William B. Peck,
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Lewellys F. Barker, Baltimore, Md.
Edward L. Bauer, Philadelphia, Pa.
Arthur Dean Bevan, Chicago, Ill.
P. Brooke Bland, Philadelphia, Pa.
Harlow Brooks, New York, N. Y.
Ralph C. Brown, Chicago, Ill.
Hugh Cabot, Rochester, Minn.
John B. Carnett, Philadelphia, Pa.
James T. Case, Chicago, Ill.
R. B. Cattell, Boston, Mass.
Henry A. Christian, Boston, Mass.
George Crile, Cleveland, Ohio
Elliott C. Cutler, Boston, Mass
Walter E. Dandy, Baltimore, Md.
Vernon C. David, Chicago, Ill.
John F. Erdmann, New York, N. Y.
John M. T. Finney, Baltimore, Md.
John R. Fraser, Montreal, Canada
Charles H. Frazier, Philadelphia, Pa.
J. Claxton Gittings, Philadelphia, Pa.
Ross Golden, New York, N. Y.
Jerry G. Goldsmith, Toronto, Canada
Evarts A. Graham, St. Louis, Mo.
Roscoe R. Graham, Toronto, Canado
R. L. Haden, Cleveland, Ohio
William D. Haggard, Nashville, Tenn.
George J. Heuer, New York, N. Y.
Emile F. Holman, San Francisco, Cal.
Campbell P. Howard, Montreal, Canada
Chevalier L. Jackson, Philadelphia, Pa.
Elliott P. Joslin, Boston, Mass.
E. Starr Judd, Rochester, Minn.
Frederick J. Kalteyer, Philadelphia, Pa.
Louis J. Karnosh, Cleveland, Ohio
Floyd E. Keene, Philadelphia, Pa.
Edward J. Klopp, Philadelphia, Pa.
Frank C. Knowles, Philadelphia, Pa.
John A. Kolmer, Philadelphia, Pa.
Frank H. Lahey, Boston, Mass.
Dean Lewis, Baltimore, Md.
Fielding O. Lewis, Philadelphia, Pa.
Warfield T. Longcope, Baltimore, Md.
William E. Lower, Cleveland, Ohio
William P. Lucas, San Francisco, Cal.
Willis F. Manges, Philadelphia, Pa.
Charles H. Mayo, Rochester, Minn.
William J. Mayo, Rochester, Minn.
Joseph F. McCarthy, New York, N. Y.
James H. Means, Boston, Mass.
George J. Minot, Boston, Mass.
John J. Moorhead, New York, N. Y.
George P. Muller, Philadelphia, Pa.
Emil Novak, Baltimore, Md.
Robert B. Osgood, Boston, Mass.
Ralph Pemberton, Philadelphia, Pa.
O. H. Perry Pepper, Philadelphia, Pa.
William C. Quinby, Boston, Mass.
Fred W. Rankin, Lexington, Ky.
William F. Rienhoff, Jr., Baltimore, Md.
David Riesman, Philadelphia, Pa.
Leonard G. Rowntree, Philadelphia, Pa.
Alfred Stengel, Philadelphia, Pa.
Cyrus C. Sturgis, Ann Arbor, Mich.
Robert G. Torrey, Philadelphia, Pa.
Waltman Walters, Rochester, Minn.
John M. Wheeler, New York, N. Y.
Allen O. Whipple, New York, N. Y.
Hugh H. Young, Baltimore, Md.

FOREIGN ACCEPTANCES TO DATE

Dr. Roberto Alessandri, Prof. of Clinical Surgery, Medical Dept., Royal University of Rome, Rome, Italy.
Dr. A. Mario Dogliotti, Prof. of Clinical Pathology, Royal University of Turin, Turin, Italy.
Dr. Hans Guggisberg, Prof. of Gynecology, University of Berne, Berne, Switzerland.
Dr. Paul Strassmann, Prof. of Obstetrics and Gynecology, University of Berlin, Berlin, Germany.

TENTATIVE:

Mr. A. Lawrence Abel, F.R.C.S., Surgeon Cancer Hospital, London, Eng.
Prof. Mario Donati, Head of Dept. of Surgery, University of Milan, Milan, Italy.
Dr. Ferdinand Sauerbruch, Prof. and Head of the Dept. of Surgery, University of Berlin, Berlin, Germany.

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42 Hawthorne Ave., Akron	Fr. 7013
1316 Mahoning Bank Bldg., Youngstown	44581
2157 Euclid Ave., Cleveland	Prospect 1951
199 Olney Ave., Marion	Telephone 2118
2651 Gilbert Ave., Apt. No. 3, Cincinnati	Wodburn 7127
2352 Monroe Street, Toledo	Main 7962
871 W. Riverview Ave., Dayton	Fulton 7211
435 E. Liberty St., Springfield	M. 191
Normandie Hotel, Columbus	ADams 1569
General Hospital, Portsmouth	559

The Ohio State Nurses' Association also operates an employment bureau where nurses may be secured for physicians' and dentists' offices, hospitals, public health nursing organizations, official health organizations, etc.

OHIO STATE NURSES' ASSOCIATION, 50 East Broad Street, Columbus, Ohio

spoke on "The Various Personality Types of People We Meet in Everyday Practice".—News clipping.

Guernsey County Medical Society in session September 6 at the Berwick Hotel, Cambridge, heard an interesting talk on "State Medicine" by Dr. D. L. Cowden, county health commissioner.—News clipping.

Muskingum County—The Muskingum County Academy of Medicine met September 5 at the University Club. The guest speaker was Dr. Jonathan Forman, Columbus, who spoke on "Allergy".—Bulletin.

Perry County Medical Society in session August 20 was addressed by Dr. John Mitchell, Columbus. Dr. Mitchell spoke on "Hay Fever and Asthma".—News clipping.

Ninth District

Scioto County—The Hempstead Academy of Medicine held its annual golf tournament and outing on September 6 at the Scioto County Country Club.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

September 17—General Session. General discussion of plans for the 88th Annual Meeting of the State Association in Columbus, October 4, 5 and 6. Open Forum, "Problems of Medicine and the New Deal", discussion opened by Drs. Platter, Price, Goodman and Sherburne.

September 24—General Practitioners' Section. Program: "Present Status of Individual Preventive Medicine in the United States and Its Territorial Possessions", Dr. Augustus A. Hall; discussion opened by Dr. Jonathan Forman and Dr. Emory Hayhurst; "Case Reports", Dr. John Rauschkolb, Dr. Richard Wallace, Dr. Richard Anderson, Dr. Paul Ross and Dr. Louis Jentgen.

NEWS NOTES of OHIO

Cincinnati—Dr. Sidney Lange, professor of radiology, University of Cincinnati, has returned from Europe where he investigated the methods of treatment employed at the Curie Radium Institute in Paris and attended the International Radiological Congress at Zurich, Switzerland.

Hamilton—Dr. William F. Vinnedge, former intern at the Jewish Hospital, Cincinnati, has opened offices here.

Vermillon—Offices have been opened here by Dr. J. Russell Dickason, who recently completed his internship at St. Alexis Hospital, Cleveland.

Dayton—Dr. Joseph Prince, former intern at St. Elizabeth's Hospital, Dayton, has opened offices for private practice here.

Grandview—Offices have been opened here by Dr. W. A. Stoughton, former house physician at White Cross Hospital, Columbus.

Green Springs—Dr. J. J. Gedert, Clyde, has been appointed head of the medical department, Oak Ridge Sanatorium, Green Springs.

Youngstown—Dr. M. H. Bachman spoke on the use of the *X*-ray in the treatment of cancer at a meeting of the local Lions' Club.

Canton—Dr. A. A. Fisher has been appointed physician for the Canton public schools, succeeding Dr. R. H. Firth, resigned.

Xenia—Dr. Ernest Ekermeyer, New Bremen, has been appointed assistant resident physician at the Ohio Soldiers' and Sailors' Orphans' Home, succeeding Dr. Harold Ray, Xenia, resigned. Dr.

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Ekermeyer will be chief assistant to Dr. T. F. Humphrey, resident physician. He formerly was resident physician in pediatrics at the Cincinnati Genueral and Children's hospitals.

Arcanum—Dr. P. G. Lenhart, former intern at the Miami Valley Hospital, Dayton, has located here.

Martins Ferry—Dr. and Mrs. R. H. Wilson recently returned from a trip through the Pacific Northwest.

Elyria—Dr. R. C. Novatney, formerly of Cleveland and Painesville, has moved here and opened offices for private practice.

Martins Ferry—Dr. B. H. Mackall, practicing physician here for more than 60 years, recently celebrated his 90th birthday anniversary.

McComb—Dr. Donald R. Brumley, first lieutenant in the medical reserve corps, has been ordered to active duty at the C.C.C. Camp near Defiance.

Jewett—Dr. James A. L. Toland has opened offices here. He is a graduate of the University of Cincinnati, College of Medicine, and former intern at Ohio Valley Hospital, Wheeling, West Va.

Sandusky—Dr. Wayne E. Brown, a native of Sandusky, graduate of Western Reserve University, School of Medicine, and former intern at Lutheran Hospital, Cleveland, has opened offices here.

Zanesville—Dr. J. E. McCormick has been taking post-graduate work at the Chicago Post Graduate Medical School.

Columbus—"The Cholera Plague in Columbus One Hundred Years Ago" was the subject of a talk made by Dr. Jonathan Forman before the local Optimist Club.

East Liverpool—Dr. Robert H. Goodwin, who has been engaged in surgical work with the International Grenfell Association in Labrador and Newfoundland for the past 18 months, was a recent visitor at the home of his parents here.

Cincinnati—Dr. Harry T. McFarland, graduate of the St. Louis University Medical School and who recently returned from post graduate work in Europe, has opened offices here. He is a native of Marion.

Monroeville—Offices have been opened here by Dr. Howard Sparks, formerly of Lorain and a former member of the staff at the Columbus State Hospital.

— OSMJ —

—A trust fund of $5,000 was bequeathed to Elyria Memorial Hospital in the will of the late Izaac D. Faxon.

—A three-day celebration was held recently at St. Alexis Hospital, Cleveland, commemorating the 50th anniversary of the founding of the hospital.

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ANNUAL MEETING, COLUMBUS, OCTOBER 4, 5, AND 6, 1934

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The OHIO STATE MEDICAL JOURNAL

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NOVEMBER 1, 1934 VOLUME XXX
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NEWS OF THE 88TH ANNUAL MEETING

Annual Addresses of the Retiring and Incoming Presidents
Proceedings of The House of Delegates and The Council
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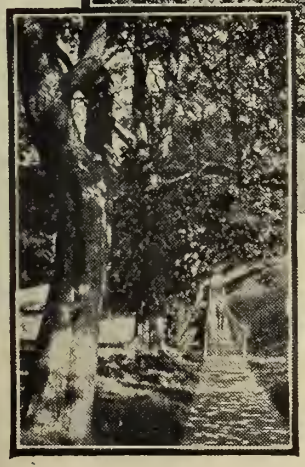
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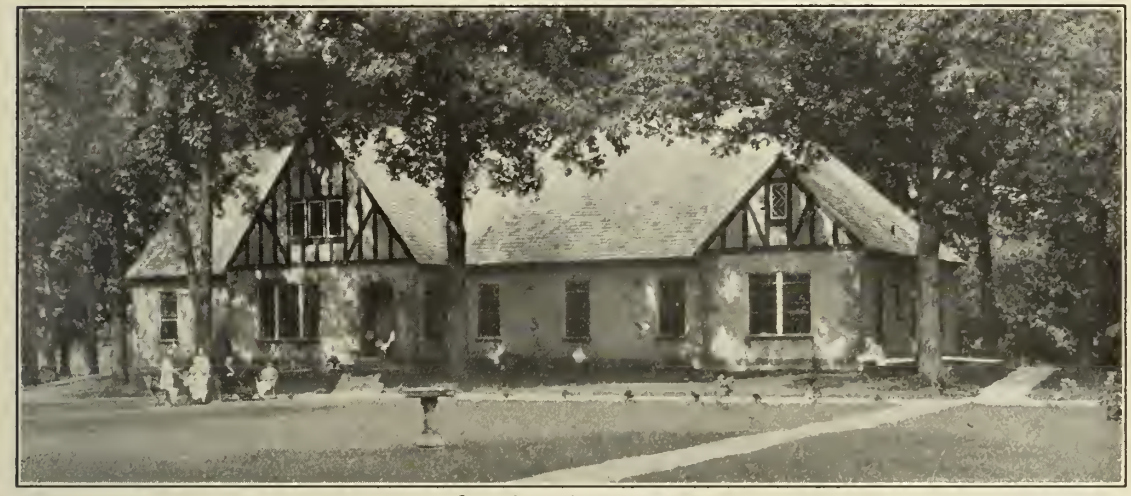
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Spirit of The Annual Meeting In Retrospect

Another anniversary of an honorable and venerable organization has passed. The 88th Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, October 4, 5 and 6, was a suitable and memorable observance of an important occasion.

Elsewhere in this issue of *The Journal* are published the official minutes of the sessions of the House of Delegates and the Council of the State Association together with news articles on the Columbus meeting.

It is recommended that every member study carefully the transactions of the House of Delegates inasmuch as they set forth the official policy of medical organization in Ohio on numerous questions likely to confront organized medicine during the ensuing year.

Those who were unable to attend the Columbus meeting may find the news articles of some assistance in obtaining information about the annual meeting, although, naturally, it will be difficult for those who were unfortunate enough to have missed being in Columbus to get from cold type the thrill produced by the constructive spirit, manifest during the two and one-half days' assembly.

Many more columns might be written concerning the 1934 meeting, how much it actually meant to the advancement of scientific medicine in Ohio and the promotion of the purposes and aims of medical organization.

Among other things the recent Annual Meeting re-demonstrated the value of organized activity and the necessity for continuous unity and harmony, essential factors in maintaining organization machinery at maximum efficiency.

Moreover, it clearly indicated that the membership is appreciative of the benefits, services, motives and activities which membership in organized medicine offers them. The active interest, fine spirit of cooperation, and sincerity shown by the representative group taking part in the meeting reflect the attitude of the great majority of the profession of the state and presage that medical organization may continue to render beneficial service to the profession and to the public.

It can be said without fear of contradiction that the medical profession of Ohio today is quite as resolute in its convictions regarding the need and value of combined effort as were the pioneer physicians of the early days of the State Association whose motives and aims were so well described in the following opening paragraphs of an address delivered by the late Dr. Edward B. Stevens, Cincinnati, at the Silver Jubilee meeting of the Ohio State Medical Association on June 15, 1870:

"All excellence is the result of individual effort. But social progress and the success of great enterprises, imply combination of labor. These two then go together—individual exertion and organized effort. The silent ant carried to its home its daily earnings—but after all *it is a poor silent ant*—though ever so busy. The winter's store is the aggregate of successive accumulations of the colony.

"All important social results are typed in this general proposition.

"Much that we do as individuals is only selfish—but wiser and better councils and purposes, aggregate the selfish labors of the individual, and develop the features of general advancement.

"Those who love the profession of medicine have steadily and steadfastly worked upon this idea. The profession of medicine in its purity—and the profession of medicine in its greatness—is the result of this sort of aggregation of personal effort, and combined or organized plan."

Naturally, organized medicine has furnished those leaders, necessary for mutual concerted effort, physicians capable of arousing in their colleagues the will to progress scientifically and the desire to unite their individual abilities for collective activities in the interests of the profession as a whole. Under this strong combination of concerted, unselfish activity and excellent leadership, medicine in Ohio has gone far and accomplished much.

Medical organization has been exceedingly fortunate during the present period of stress and uncertainty to have had at its helm real leaders. Especially during the past year, probably the most critical in the history of the nation, medical organization would have been unable to cope with many of the serious problems which confronted it had it not been guided by the type of leadership exemplified by the presidency of Dr. C. L. Cummer, Cleveland.

Confronted with an unprecedented number of serious public and professional problems, Dr. Cummer was inaugurated over a year ago under most trying and turbulent conditions, making his record as president all the more remarkable. Courageously and wisely he guided the State Association through the maize of difficulties so well known to every member. His genius for organization, tireless zeal, keen judgment, indomitable

faith in the principles and policies of organized medicine, aggressiveness, and ability to restore confidence, courage, harmony and concerted activity among the profession as a whole were primarily instrumental in maintaining the interest and enthusiasm of the membership at a high pitch and stimulating the kind of organized activity that produced results of distinct benefit to every member of the profession. The membership owes to him its deepest appreciation, admiration and respect. It could desire nothing better than that his record be considered as an example of the kind of leadership to which the medical profession of Ohio is entitled.

Fortunately, the State Association, with Dr. John A. Caldwell, Cincinnati, as its newly installed president for the ensuing year, may be confident that the interests of the profession will be well preserved. Experienced in organization activity, devoted to the aims and motives of medical organization, commanding the esteem and affection of all among his wide acquaintanceship, respected for his judicious views and the courage of his convictions, and firm in his desire to serve in such a way that scientific medicine, the profession and the public will benefit, Dr. Caldwell enters the presidency well qualified and possessing attributes of meritorious leadership.

By electing Dr. R. R. Hendershott, Tiffin, as president-elect, the House of Delegates made certain that there shall be continuity in high caliber of leadership which the State Association has had for many years. Dr. Hendershott, a former member of the Council, has had much experience in the activities of organized medicine. He has for many years been a leader in the profession in his own community and frequently has been called upon to serve as a member of important committees representing the State Association. Modest and retiring but sincerely, earnestly and constructively interested in the programs and activities of medical organization; and possessed of the wisdom and judgment which frequently distinguish those who say little but think much, Dr. Hendershott frequently is sought by his colleagues for advice and counsel. Fundamentally he is well equipped to contribute to the State Association the able leadership it will need and expects.

— OSMJ —

Social Medicine Programs Imminent

If recent developments bearing directly on scientific medicine and medical practice have been interpreted correctly, there is no doubt but the coming months will be fateful ones for the medical profession and challenge every ounce of strength, initiative and courage it will be able to muster through the facilities of medical organization.

In his presidential address at the recent Columbus meeting of the State Association, Dr. C. L. Cummer summarized in a timely and comprehensive way some of the important developments in our national life which have combined to make the present and the immediate future the most critical period the medical profession has ever faced.

Dr. Cummer in his address, the complete text of which is published in this issue of *The Journal*, pointed out with emphasis that the medical profession is confronted with positive facts, not a fictitious bogey, and must put its heart and soul into a concerted effort in defense of its position, or witness the destruction of the established, independent system of medical service.

Those who have followed developments in well-organized programs purporting to bring about "economic security for the individual and his dependents in all the vicissitudes and hazards of life" will readily realize the acuteness of the present situation as it affects medical practice.

Secretary of Labor Frances Perkins, writing in the last issue of *The American Labor Legislation Review* under the suggestive title, "On Our Way", optimistically declared that "we are well started on our way towards the execution of that task", referring to the work of President Roosevelt's Committee on Economic Security which, in brief, involves the drafting of legislation to be presented to the next Congress providing for all forms of social insurance—workmen's compensation, accident, *health*, *invalidity* and unemployment insurance, retirement annuities and old age pensions, security for farmers and agricultural workers, survivors' insurance, *family endowment and maternity benefits*, and assistance to dependent children and families without breadwinners.

Heading the study on medical care for people of low income groups are Edgar L. Sydenstricker and I. S. Falk, staff employes of the Milbank Memorial Foundation, whose views and those of their employer in favor of the complete socialization of medicine are well known to the medical profession. Therefore it is a matter of conjecture what disposition would be made of any information and suggestions medical organization might submit should the committee see fit to give the medical profession an official voice in the contemplated program.

It is no secret that one objective of the New Deal *social security program* contemplates forcing action by the legislatures of the various states on some of the proposals now under consideration, including compulsory state health insurance and kindred social insurance plans.

At present, an organization known as the American Association for Social Security, Inc., headed by Abraham Epstein, long a promoter of all kinds of social legislation, is already putting the finishing touches on a bill for health insurance to be submitted to the different state legislatures

during the ensuing year. The connection between Mr. Epstein's organization and the Committee on Economic Security, if any, is not clear. However, among those listed as officially connected with the American Association for Social Security, Inc., are certain so-called advanced thinkers on social questions who have been consulted in an advisory capacity by President Roosevelt's economic security investigating group.

Those looking for significant facts were interested in newspaper articles concerning the recent sessions in Cincinnati of the Ohio Welfare Conference and the National Conference of Catholic Charities. At both conferences the question of health insurance, together with other social insurance schemes were discussed. Alden B. Mills, Chicago, editor of *The Modern Hospital*, in an address to the welfare conference is reported to have declared "we must have either health insurance or state medicine to bring medical care within the reach of all the people", while Dr. John O'Grady, Washington, secretary of the Catholic charities meeting, was quoted as having advocated "direct responsibility for unemployment and old age insurance by the federal government, with health insurance set up on a state basis". Other reports on the two meetings indicated little opposition to the principles involved in the question of health insurance but considerable differences of opinion as to whether the undertaking should be assumed by the federal government or left to the individual states.

The foregoing facts have been presented to give the medical profession additional information regarding the imminent and important situation confronting it and to impress upon every physician the increased necessity for cohesion and organized action on the part of the profession during the troublesome and uncertain months to come.

The prediction made by one enthusiastic supporter of all types of social insurance that the procedure now being developed under official guidance at Washington "will so capture the imagination of the public that an overwhelming popular demand will force through Congress and the state legislatures this coming winter the whole program of economic security" cannot be treated as mere propaganda nor beyond the realm of probability.

As the Council of the State Association pointed out in an official statement issued recently (August, 1934 issue of *The Journal*), the future trend, tendency and structure of government in this country and those services, including medical service, which contribute to social welfare will be determined by the next Congress and state legislatures. The first duty of the medical profession, therefore, is obvious. "In this crisis it is a patriotic duty to be politically-minded" is the warning which the medical profession must follow or suffer consequences certain to follow with rapidity and devastating results.

— OSMJ —

Cooperation In Relief Problems Is Possible

Ever since, and previous to, the inauguration in Ohio of the present system of providing medical care of the needy under the rules and regulations of the Federal Emergency Relief Administration, the officers and committees of the State Medical Association have attempted to cooperate with and assist the State Relief Commission on medical problems.

As the members of the State Association know, the State Relief Commission has shown a reluctance to accept the assistance and advice of the representatives of medical organization. Neither has it made possible frequent conferences on medical questions where difficulties could be aired and readjustments discussed.

There is nothing in the federal rules and regulations governing the expenditures of federal funds for medical care of the indigent which prevents the fullest cooperation between relief officials and the organized medical profession. As a matter of fact, Rules and Regulations of the F.E.R.A. encourage, and in effect insist upon, negotiations between state relief officials and medical organization.

The relief officials of some of the states have attempted to comply with the implications and spirit of the federal regulations by making possible mutual cooperation between the medical profession and the relief administration. For example, we quote from an editorial published in a recent issue of *The West Virginia Medical Journal*, commenting on the medical relief situation in that state:

"Several days ago the West Virginia Relief Administration sent out a bulletin to all county relief administrators insisting that the county administrators seek a closer spirit of helpfulness and cooperation from the local county medical societies. This bulletin called attention to many of the problems incident to medical aid to the unemployed and pointed out that such problems could not be successfully handled except through and by the county medical societies or their representatives. We heartily concur with the spirit of this bulletin.

"The major problem listed in the above mentioned bulletin concerned the authorization of non-emergency cases. The bulletin pointed out that the medical profession was making quite a sacrifice to take care of relief cases at one-half or less than half of their regular rates. The bulletin then went on to say that relief administrators should not take advantage of the profession by authorizing medical care unless it was really necessary. 'If you are in doubt as to what constitutes a medical emergency,' said the bulletin, 'that is the first

problem you should take up with your county medical society.'

"On the subject of padded bills, the bulletin stated that there had been some evidence of this evil. 'We feel,' the bulletin pointed out, 'that this condition can be almost entirely eliminated by asking your county medical society to go over the monthly bills of its members. A doctor might attempt to put over a padded bill on a lay administrator, but he would think twice before attempting to put something over on a committee of his medical confreres.' The bulletin suggested the possibility of an alternate medical relief committee in some counties if the regular members do not wish to go over their bills.

"We are glad to see the West Virginia Relief Administration with such an apparent appreciation for the services of organized medicine. We feel that this attitude is almost entirely due to the service rendered the administration by the medical relief committee of the state association. The three members of the state committee meet regularly each week with the relief administration to adjust problems and details sent in by county administrators and county medical societies. Apparently the West Virginia Relief Administration feels that the same spirit of harmony and cooperation should be a part of the relief program in each county in the state.

"The weekly meetings of the state medical relief committee have been copied with unusual success by several of the larger county societies. We believe that the relief committee of each county society should have a regular meeting date with the county administrator to handle the problems that are now being sent up to the state committee. In any event the relief administration has insisted that all county administrators cooperate fully with the various county medical societies. We urge the county medical societies to show a similar spirit of cooperation toward their local relief administration."

It is unfortunate, as well as disappointing, that the state relief officials in Ohio have not taken medical organization into their confidence and made it possible for representatives of the medical profession to work with them on problems arising in connection with the medical relief program, something the medical profession desires and has sought to do on numerous occasions with little success.

Although the state relief officials in Ohio may continue to manifest a spirit of indifference toward organized medicine, this does not necessarily mean that medical organization should, or will, discontinue its efforts to improve the present medical relief set-up and if possible convince relief officials of the necessity and importance of cooperation between medical organization and relief administrations.

As has been pointed out repeatedly in *The Journal*, there is nothing to prevent a local relief director from organizing a local medical advisory committee, with the assistance and cooperation of the county medical society or academy of medicine, in his county. In fact, the representatives of every county medical society should insist that this be done.

Some local relief directors have sought, and have received, the advice and assistance of medical organization in their county, despite lack of encouragement or specific orders to do so on the part of the state relief officials. It is hoped that this cooperative idea will gain momentum, for the medical relief plan is functioning much better in such counties than in those where no efforts to bring about an understanding and cooperation between the local relief administration and the medical profession have been put forth.

Until there is a better understanding and greater cooperation between relief officials and the medical profession in all parts of the state, Ohio's medical relief plan will not function effectively.

—OSMJ—

Re Centralized Medical Service

Experiments in methods of distributing medical service to patients of the so-called middle class on a flat-rate basis and with a hospital or medical center as the hub of the system are developing rapidly.

However, until it has been demonstrated that these programs are in accord with sound principles and procedure, it is important that they be subjected to critical analysis.

A number of important and fundamental questions arise in connection with ventures of this sort:

Are those receiving the benefits of the service offered at reduced charges paying as much as is right, considering their earning power?

Are the interests of all members of the medical profession being served or are a comparatively few receiving whatever benefits are available?

Is the plan competing unfairly with physicians of neighboring communities by serving their patients who are attracted by the lower rates?

Is the type of medical service rendered as good as that received by patients who are not eligible to become beneficiaries of the reduced-fee plan?

Is it conducive to good service and is it sound economics to standardize physicians' fees under a rigid schedule of so much per ailment and so much per type of service regardless of the complications encountered?

Should the physician's fee be determined solely by himself, limited by his private generosity and the financial means of the patient, or should the fee be fixed by prearrangement between the physician, patient and medical center?

Do the rates and charges agreed upon insure a fair return for those rendering the professional service?

Are sound actuarial standards being used in the financial set-up?

In all probability there are other pertinent questions which might be asked in connection with experiments now under way.

SCIENTIFIC MEDICINE IN THE CHANGING SOCIAL ORDER

Annual Address of The Retiring President

By CLYDE L. CUMMER, M.D.,

Cleveland, Ohio

The Ohio State Medical Society was established at a meeting held in the old Neil House on this very site on May 14, 1846, so that this is the eighty-ninth year of its existence. Almost certainly no one is now alive who aided in the formation of the Society; we have to rely upon the records to ascertain the motives which actuated the founders of our now venerable organization. In the archives of the Cleveland Medical Library I found a printed volume with yellowing pages, the first Transactions; and in consulting the original constitution found that "the Society shall constantly have in view, first, the association of the Profession, for the purposes of mutual recognition and fellowship; second, the maintenance of union, harmony and good government among its members, thereby promoting the character, interest, honor and usefulness of the Profession; third, the cultivation and advancement of medical science and literature, and the elevation of the standard of professional education".

These objects remain as ours today, but with the passing of the years, we have added others, or perhaps we have merely increased the emphasis by stating them specifically whereas they might have been read into the first constitution by implication. An object engrossing much attention at present, i.e., to safeguard and foster our material interests, was not mentioned. That we are obliged to place emphasis upon this is not by our own choice; it is enforced by the pressure of social and economic conditions and by the activity of groups striving to undermine the traditional patient-physician relationship.

The government of the Society has undergone changes since those early days. For years, the State Association has not had power of electing its own members, in the first place; and secondly, it is in reality a federation of the county societies, which in the last analysis is governed by them through the action of their representatives in the House of Delegates. Representative control in the formulation of policy is vitally important, in view of economic conditions, for only in this way may be secured unity of purpose and action.

The House of Delegates is the legislative body of this Association, the Council being elected by it, and carrying on its functions under the former's direction between the annual sessions. Furthermore, the House of Delegates is representative of the county societies, for any county no matter how small its membership, is entitled to at least one representative, while counties with membership exceeding one hundred are allowed one delegate for each one hundred members or fraction thereof.

For many years the actions of the House of Delegates have guided the Council and officers by means of resolutions and reports which have been adopted from time to time and which in the aggregate compose the policies of this Association. There is scarcely a topic of importance with economic or social bearing which has not been considered in this way and therefore there is ample record of the official sentiment of the Association. These policies have not been formulated by any one man or by a group of men, but by the action of this representative body. Surely such a form of government is as democratic as can be devised and still be efficient, but it has the inherent weakness of democratic government in depending upon the continued interest of its constituency to express itself through the means provided.

HIGH POINTS IN THE YEAR'S ACTIVITIES

I shall now give you a brief summary of the way in which the officers and Council have fulfilled the obligations of their stewardship during the past year. Questions of public policy were foremost in the minds of the Council during the year because of the protracted and well-nigh chaotic legislative session and because of the medical aspects of the Civil Works, Public Works, and Federal Emergency Relief Administrations, all of which introduced problems of primary importance since last September. Although over 100 bills of medical bearing were introduced during the last session of the Legislature, none inimical to the interests of scientific medicine were passed. This record constitutes a testimonial to the activities of the Policy Committee, our alert headquarters staff, and the legislative chairmen of the county societies supported by the cooperation of the membership.

For some time we had tried to secure compensation for physicians rendering professional service to indigents. In view of payments made out of public funds for shelter, food and clothing for the needy, the justice of payment by the government for equally necessary medical service seemed too obvious to require argument. Finally in the early fall of 1933 an announcement was made that funds would be allocated for this purpose. A fee

schedule pathetic in its inadequacy was announced without the approval of this Association or its officers. About the time of that announcement, the Federal Government issued Federal Regulations 7, which provided that the presidents of all state medical associations would be members of advisory committees to the respective state relief commissions. Your president was so appointed and in the early fall attended two meetings of the advisory committee but never met any member of the Relief Commission and was unable to secure any change in the fee schedule.

Numerous unsuccessful attempts were made to appear officially before the State Relief Commission, the nearest approach being an audience granted by the chairman, General Frank D. Henderson, and his aide, Major E. O. Braught, with negligible results. Finally an appointment was secured with Governor George White to whom a detailed statement was made, after which the fee schedule was increased to more reasonable figures. This would be gratifying were it not for the allocation of only $1.00 per family per month for medical service. Because of this arbitrary limitation, the funds available are pro-rated among the physicians rendering such services, many of whom may have received only a fraction of the amounts really due them.

GROUP INSURANCE PROBLEMS

Another important question involving policy is that of hospital group insurance. The recommendations of the Council were that those county societies faced with such projects in their communities proceed slowly in giving approval because of the difficulty in the suggested plans of completely separating hospital from medical service and because of the great possibility, if purchase of hospitalization on a group plan proved feasible, of mis-educating the public to the apparent desirability of attempting to obtain medical service in similar manner.

WORKMEN'S COMPENSATION DEVELOPMENTS

The relations of physicians with the State Industrial Commission have been a subject of constant consideration by the Council for many years and many beneficial changes in procedure have resulted from the suggestions of this Association. The special committee appointed this year has been especially fortunate in its relations both with the Commission itself and with a committee appointed by the Governor to study its structure and workings, headed by Mr. S. P. Bush of Columbus. The latter committee has sought the advice of our Association, and some of our recommendations have been adopted.

We have advocated fundamental changes in the organization of the Medical Department including a plan for impartial Regional Medical Boards of Review to pass upon protracted, revived, or contested cases. This work has been of genuinely constructive nature and if the suggestions are carried out, they are certain to aid in the conservation of the Workmen's Compensation Fund and in insuring just treatment both to employers and to employees, as well as to honorable physicians engaged in this form of practice. We regard our relations with the Industrial Commission and with the Governor's committee and the success of our advice to them, as one of the real achievements of the year.

MEDICAL EDUCATION

The problem of the continuing education of doctors, often called post-graduate work, has received earnest consideration and the Council has given approval to a proposal for study-outline courses recommended for use by the component county societies. A physician can never be satisfied with his original training; it must be constantly brought up to date. He must not only be educated, but he must keep educated. This can be accomplished by clinical observation, by reading, study and investigation, by attendance upon medical meetings, and by graduate instruction. Unfortunately it takes both money and time and, consequently, loss of income to journey to medical centers for even short post-graduate courses; therefore it is incumbent upon this Association in compliance with our ideals and announced purposes to further other forms of graduate instruction. This may be done by bringing to Ohio great national medical assemblies, which is possible only at intervals; by the annual meetings of this Association; by review courses in the societies located in the larger medical centers; by post-graduate weeks or days in connection with district meetings; by hospital staff meetings; and by definitely planned programs for county meetings which require individual study by the members followed by general discussion. We hope that the last-mentioned plan, endorsed by the Council and outlined in recent issues of *The Journal*, will be given a thorough trial by many county units, especially by those more remote from the larger medical centers where the members are more dependent upon themselves and each other.

The meeting of the American Medical Association in Cleveland in June was attended by 2,122 Ohio Fellows, representing more than a third of our entire membership, and those who attended profited by the splendid sessions and the tremendously instructive exhibits. Our own annual meeting now in session brings the year to a fitting climax with a splendid program representing the culmination of efforts started over two years ago to make our sessions interesting and instructive especially to general practitioners.

OUR MEDICAL JOURNAL

The educational importance of the *Ohio State Medical Journal* will be more apparent when I tell you that of our State Association membership of

5,200, only 3,100, or approximately 60 per cent, are Fellows of the American Medical Association and so receive its *Journal*. Therefore the *State Journal* is probably the only scientific medical periodical reaching regularly the other 40 per cent of our membership. Of this publication we have especial reason to be proud. It was one of the first state journals to adopt a policy of admitting to its advertising pages only such pharmaceutical preparations as have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association, a policy unfortunately not yet universal with all state journals. Furthermore, close scrutiny of scientific manuscripts is the rule; and the mere fact that a paper has been read at one of the annual meetings of the Association does not entitle it to publication unless it possesses the literary and scientific qualities demanded by the Publication Committee.

The articles on social and economic movements and legislative developments are prepared after careful and thorough study based on the results of contacts with governmental departments and other official and non-official agencies, and they present the current trends clearly and concisely. Their informative value is very great; a physician who is interested in his own future and that of his profession cannot afford to overlook them. The news of state and county society activity is of present-day interest and historical value. All in all, *The Journal* constitutes one of the great services rendered by this Association to us all.

DEFENSE AGAINST MALPRACTICE SUITS

Another invaluable service is rendered by the Association's system for *Medical Defense*. This activity was inaugurated eighteen years ago. Members are provided with legal defense if sued for malpractice, subject to certain reasonable restrictions and provided they are members in good standing both when the alleged malpractice occurred and also when suit was instituted. With long experience resulting in the acquirement of much technical knowledge, the committee has been able to aid greatly in the preparation of defense and especially in the prevention of such suits. Many physicians have benefited incalculably from this feature of our work.

BUSINESS AND EXECUTIVE FUNCTIONS

The membership of our Association has shown a substantial gain over this corresponding time a year ago, which doubtless reflects in part some improvement in the economic situation, but especially the realization by our members of the increasing importance of sustaining the Association's activities. Our financial affairs have been handled soundly, and the reserve for emergencies has been safely conserved. Note should be made of the fact that during the year our headquarters were moved to much better offices in a more accessible location and at no increase in rental. All in all, the management of our business affairs has been most creditable.

The Association is especially fortunate in its headquarters staff. Our executive secretary, Don K. Martin, came to us with unusual qualifications for his responsible post, having had prior knowledge of public affairs and the technic of publicity gained through practical experience as a newspaper man. In addition he possessed knowledge of the law, having been admitted to the Ohio bar. He has now completed fifteen years of loyal and devoted service to us, and the success of our efforts in the field of public relations as well as within our own organization is due largely to him. He furnishes the continuity in policy and procedure so important in any organization but often difficult to attain with the constant and inevitable changes in the personnel of officers. His assistant, Charles S. Nelson, and the other members of the staff have been devoted to our interests and the success of *The Journal*, and the various committees have been aided greatly by them.

To carry on successfully the numerous activities of the Association without the self-sacrificing and loyal efforts of many workers would be impossible. To the Councilors and all committee members who have made the year's record possible I wish to extend my appreciation, with the feeling that the membership at large is deeply indebted to them.

THE FOUNDATION OF ORGANIZATION

The success of our efforts depends upon efficient coordination between the centralized State Association on the one hand and the component county societies on the other. The county societies are the building stones which form the Association and their strength is essential to its proper functioning. In each county the physicians have urgent need for an active society as a forum where they may interchange views regarding medical practice and as a meeting place where they may be drawn together through mutual aims and interests for their common good. This Association in turn requires an active society in each county so that members may be kept in touch through our *Journal* and its meeting with scientific progress and with the problems and aims of organized medicine, and so that medical organization on the other hand may have readily available means through county officers and committeemen of keeping informed as to the local bearings of state-wide questions. It is far from sufficient to have active groups in the majority of counties; we should have an aggressive and informed society in every county. While the merger of several adjoining counties into three- or four-county societies may seem to possess certain advantages, these are more than offset by accompanying serious drawbacks. Members are never as acutely interested as in their own home county organization; attendance often drops off

due to difficulty in reaching more remote meeting places in other counties; the increased tendency to import speakers has discouraged personal scientific effort; and the State Association feels the loss of alert and complete organizations in each county.

It is hoped that smaller societies which have affected mergers because of program difficulties will revive their separate organization identities and meet as individual societies several times a year, using the study outlines which have been proposed or the round-table type of discussion. If deemed advisable and necessary, they may meet two or three times yearly as combined societies to hear guest speakers. In such manner, two purposes will be served, i.e., first, local men will furnish programs and their interest will be aroused, both in the progress of medicine and in their own society, and secondly, active organizations will be ready to function in each county.

I appeal for the continued interest of loyal workers both in our State Association and in the county societies. Today we need coherent and aggressive organization as never before. Present conditions bring ever-changing problems to us. May the active county societies sustain interest at high pitch; where indifference has dulled efforts, may some zealot come to the fore to stimulate enthusiasm. We who have worked for years in organized medicine have often seen an apparently moribund county society brought to life simply because one dauntless spirit would not accept his first defeat and persisted in the determination to have an active and useful medical society in this county. For someone there is always opportunity.

SOCIAL AND GOVERNMENTAL INVOLVEMENTS

The historic structure across the street, sheltered behind the trees and hemmed in by the modern buildings surrounding State House Square, serves to remind us that we are meeting in the capital city of our state, the hub of innumerable and ceaseless governmental activities which reach into the life of every one of us in ways we seldom realize. Within its massive walls governors, some famous and some almost forgotten, and a host of legislators have played their brief roles and have departed. From its broad steps Lincoln appealed to Ohio to help save the Union. From its executive office Governor Dennison issued his calls for volunteers, which brought thousands of loyal sons from Ohio farms and cities to join the Union armies. There Hayes, McKinley and Harding served their state before becoming chief magistrates of their country. History surely has been made under that dome. But history is really made in other ways—in the movement of people in quest of home and fortune, in the effects of improved transportation and means of communication on human activities, in the development of natural resources, and in the application of scientific discoveries to the use of man.

Ohio, once largely agricultural, has become increasingly industrial. Its villages have become towns, its towns have grown to cities, and the small cities our founders knew have spread far from the limits of their Main Streets into huge centers crowded with all sorts and conditions of men whose personal aims and political ideals differ sharply from one another. From these congested urban centers radiate spider webs of railways and motor roads, interlacing over the countryside, where the dwellers again have different problems, different aspirations, and different political convictions. The result is a loss of homogeniety and solidarity, an uncertainty as to what really constitutes the rightful function of government. Then, too, the governmental isolation of the separate states is no more; the conception of states' rights has passed almost into the limbo of curious and obsolete doctrines, and there has arisen the idea of the super-state. As a result the problems we face today are far different from those of our predecessors who met on this spot in 1846 to found the Ohio State Medical Society. They were almost 90 years closer in time to the settlement of this country, closer by just that much to the pioneer spirit. They lived in an age of individualism and self-dependence; we in one in which individualism is derided and apparently in which dependence upon a paternal state is to be encouraged. Yes, even made obligatory. Whether we desire it or not, the relation of ourselves and our profession is no longer a matter between us and those whom we would serve but for the super-state which in its presumed wisdom professes to know all, think for all, and regulate the activities of everyone.

The ominous developments of the last year as they affect the practice of medicine are too well known to you to need even a summary by me; the climax is still to come, heralded as a program to bring about social security for all.

FUNDAMENTALS OF SOCIAL SERVICE

Concentration of population and the vicissitudes of modern life demand the continuous development and perpetuation of scientific medicine. We must be adequately prepared not only to render individual professional service to individual patients, but to help solve the problems of the still undiscovered causes of many diseases. In a broad sense organized society perforce depends upon us for the preservation of public health, physical virility and mental power. This then is our burden in a chaotic era of changing social philosophy.

Naturally, society must make provision for those who are unable financially or otherwise to provide their own necessities, including medical care. However, as members of a scientific and

humanitarian profession, we should be peculiarly and directly concerned about a social philosophy in which government seeks to regulate personal service as well as property. Stifling of personal opportunity, destruction of initiative and a deliberate redistribution of property cannot avoid bringing with them a paternalistic state which will consume but not create and by indefinite expansion will inevitably crash of its own weight.

There can and should be reform without revolution, without abandonment of personal opportunities, without relinquishment of liberty and democracy guaranteed by the Constitution on which our heretofore great country was founded. Remedies necessary for an emergency should not be projected into permanent governmental policies. A serious infection does not necessarily justify a radical amputation or a "remedy" so drastic that the entire structure is permanently disabled. As physicians we have learned not to imperil our patient's life with too heroic treatment.

THE COST OF MEDICAL CARE

In the last two years we have heard much about the alleged high cost of medical care, which furnishes the ostensible motive for agitation for changes in the form of medical practice in the direction of state or other types of socialized medicine. It is admitted that medical care can be made costly by ultraspecialism, by excessive and unnecessary laboratory and other diagnostic tests for trivial affections, by indulgence in private hospital rooms and superabundance of private nursing service. This is not the fault of the medical profession; it results from popular demand and from the misconception that expensive care is necessarily better care, and that better care is therefore expensive.

As a profession, our attention should be focused on the high cost which results from poor medical service and from unnecessarily luxurious care, and those responsible for the business management of hospitals should make it their duty to avoid overselling accommodations to the sick, helping them instead to fit their expenditures to their purses and to their necessities. If people desire mere luxury when ill and can afford to pay for it, certainly that is their right, but all should be informed frankly as to what is luxury and as to what is really unnecessary to speedy recovery.

The presumed high cost of medical care—and unfortunately the figures which have been issued often include expenditures even for patent medicines and for sectarian practitioners—could be greatly reduced by educating the public to call qualified physicians promptly on the appearance of symptoms of illness, thereby cutting down on the period of disability; by urging them to employ general practitioners whenever possible, reserving the use of specialists for conditions with which the family practitioner is unable to cope; by showing them the folly of demanding superluxuries in hospital accommodations; by having them avoid the use of sectarian practitioners and faddists because their insufficient training does not qualify them to take a broad view of medical problems; by demonstrating to them the fallacy of relying upon self-diagnosis and self-treatment with proprietaries, no matter how well advertised they may be.

An enormous sum of money was spent in promoting, conducting, and advertising the survey of the so-called Committee on the Costs of Medical Care, all to obtain statistical data which were rendered obsolete by changing economic conditions soon after publication. If the great foundations which fostered this project had spent the same money to further the education of the public along the lines we have just indicated, the ultimate purposes of this costly undertaking would have been advanced far more.

For years physicians have borne the brunt of self-education, of trying to warn the public against unqualified practitioners, of doing charity work for the indigent (a class of sufferers which has no especial appeal to the cultists or dealers in proprietaries), only to be repaid now with a burst of propaganda aimed at socializing the doctor against his will.

A CONSIDERATION OF SOCIALIZED MEDICINE

The physician has been denounced by some critics as too strongly individualistic. Individualistic he undeniably is, and such a tendency is the natural result of his contacts with life. Fundamentally he is such because his life's work is with individuals; and his experience has shown him that success depended upon his power of individualization, on his analysis of a patient's peculiar medical problem, viewed in the light of his heredity and his social and environmental background. With sick patients he cannot deal successfully as the letter carrier does with the contents of his mail bag. Patients demand and are entitled to receive the sympathetic, intelligent, and thorough care entirely possible under the present system of medical practice but utterly impossible under any of the systems of mass or socialized practice attempted abroad.

We have consistently opposed the complete socialization of medicine, not on selfish grounds but on the basis of concern for our patients and the general public, basing our objections on the following reasons:

(1). Such systems would handicap, perhaps even destroy, the traditionally intimate and personal relationship always existent between patient and physician by the interposition of countless officials and by the infliction of innumerable official reports which as public property would violate professional confidence.

(2). Socialized medicine would increase the

expenditure for medical service to the community as shown by experience in European countries, and the added cost would come from the already sadly depleted pockets of the taxpayers.

(3). Socialization of medicine would inevitably tend to prolong the convalescence of the average patient, for again the experience of other countries has shown that the length of disability has steadily increased due to the co-relationship between cash benefits and medical service and to the tendency for the insured to convert sickness insurance into a form of dole.

(4). The quality of medical service would probably deteriorate since socialized or mass medicine by its very nature encourages slipshod methods and thereby prolongs the period of illness and consequently disability.

(5). The advance of scientific discovery would be arrested because socialized medicine discourages personal ambition and dampens the ardor for scientific endeavor.

In short, socialized medicine would be subject to great evils, including high administrative cost, clumsy mechanism and political favoritism in a huge machine operated by an army of employes.

THE CHALLENGES OF TODAY

In spite of our intense distrust and dislike, based on our conception of the public good, it is possible that the avalanche which has engulfed other groups much stronger than our own, will overtake us. When our opposition proves futile, if this be the unhappy outcome, it is incumbent upon us collectively and individually, to bend every effort to secure the recognition of those principles which were so well expressed in the resolution adopted by the American Medical Association at its Cleveland meeting, principles which are based firmly on the rightful conception of relationship between doctor and patient.

While the present situation is serious, it should not be regarded as hopeless. The next Congress will have placed before it many proposals of grave import to us and it may enact legislation changing our entire social structure. It is therefore vitally important for us in every section of the State to ascertain the attitudes of all candidates toward the socialization of medicine and to make certain that each one understands the reasons for our objections. It is perfectly proper, indeed it is our duty as patriotic citizens, to support those whose principles accord with our own. This applies likewise to candidates for state offices, for here also important actions are certain to be undertaken. These remarks are entirely non-partisan in character; in both major political parties are those who think with us and those whose concepts differ strongly. Our convictions are not based on party platforms but on a philosophy regarding social welfare and how it may be best attained.

Regardless of the outcome of the present state of social and economic unrest, strong and representative organization will be more necessary than ever before. Physicians as individuals will be utterly powerless to deal with bureaus and commissions, but eventually even a super-government will find advantage to itself in bending a conciliatory ear to strongly organized groups. The records of past years and especially the Council and committee reports of this year show clearly how this Association has met the increasingly complex problems which have arisen, and of the services which it has rendered and must continue to render to the membership.

Our strongest defense always will be based on giving the best medical service possible at reasonable cost, and thereby convincing the public that it is better served under an established and proved system than it would be under any other. It behooves us all to bring our methods of practice up to modern standards; to keep thoroughly abreast of the times scientifically; to attend our patients with the greatest diligence and skill at our command; to make our fees commensurate with the value of the service but always reasonable; and so to show them, and through them the general public, that they are better off with such individualized care than they could possibly be with any method of mechanized practice. We must convince the public that we who have met the rigid qualifications exacted of us by the state have the right to expect freedom from unfair competition or the obligation to work as creatures of a super-state, and that the better our circumstances, the better prepared we will be for service. The community will never gain by regimented and time-serving doctors.

Yes, the challenges to us are many. There will always be need for good medical service. It is an essential of modern life. We must keep abreast of scientific progress and be prepared to care for the sick who seek our aid, kindly and efficiently. These are among our major problems; we should not be obliged to fight for the right to do these things. In all this time of strife and difficulty, let us keep our minds clear and ever be true to that vision which first beckoned us to the practice of medicine as our life's work.

— OSMJ —

The Cleveland Medical Library Association celebrated its 40th anniversary with a dinner honoring its charter members on October 19 at the Allen Memorial Library. Special entertainment features were presented under the direction of Dr. Harry V. Paryzek and Dr. L. A. Pomeroy. Two addresses were made, one by Dr. W. E. Bruner on "Founding of the Library", and one by Dr. H. T. Karsner in extending a greeting to the charter members. Dr. R. H. Birge is president and Dr. T. P. Shupe, secretary, of the association.

BASIC PRINCIPLES IN MEDICAL SERVICE

Inaugural Address of the Incoming President

By JOHN A. CALDWELL, M.D.,

CINCINNATI, OHIO

Any person must be made of unimpressionable material who is not moved by being selected by his confreres as the head of a body such as one of our associations. When the selection comes from the Ohio State Medical Association, the splendid record of the Association and the long list of faithful, self-sacrificing, earnest and often eminent practitioners who make up our list of Past-Presidents, makes election to the office of President an event which fills the recipient with deep, solemn appreciation for the honor, and at the same time, concern, lest he fail to measure up to his predecessors.

Any feeling of pride or gratitude which one may have at being singled out as your President, is considerably diluted when the recipient is confronted with the constitutional requirements, that he shall deliver two addresses, one on assuming the chair, the other on leaving it, and he sets to work to prepare his address. In these, he is supposed to draw just conclusions from the past, comment usefully on the present, and indicate a proper course for the future. When one considers that he is to do these things before several thousand physicians who are his equal or superior in education, experience and training, it is not to be wondered that he bewails the fact that Divine inspiration is not nowadays conferred on those in high places.

In addressing you, I am entirely mindful that I possess only such qualifications as come from many years' practice of our profession and close association for the past six years with others who have studied, labored and deliberated over medical problems.

Physicians are made of the same ordinary clay which goes to make up the physical, moral and mental structure which we know as man. In some degree this clay is refined, by a medical education, by the inculcation of medical ideals and ethical codes, and to varying degrees the assimilation of such creditable ambitions as self-improvement, as well as self-sacrifice. But, fundamentally the basic clay is present and occasionally when thoroughly panned is found to yield some dregs of self-aggrandizement, oppression, extortion and trickery. No one appreciates this scum of dross more than the physicians themselves, and they have persistently endeavored to improve the quality of those who take up the practice and such improvement as has come about has come entirely from within and most frequently has had to overcome the opposition of those toward whose interests the reform was directed. The most notable examples of misguided opposition, are those against vaccination, immunization, animal innoculation and experimentation.

ECONOMIC AND SOCIAL PROBLEMS

It has only come about within the past few years, however, that those outside the profession have directed their efforts to changing the personal and economic relations between the doctor and his patient. Most of the various projects proposed to relieve the overburdened patient have had their origin in the minds of persons who are so situated that their financial condition leaves them abundant leisure to concern themselves over the affairs of the less fortunate members of society. In their groping for things to rectify, they have found a crying need in the "high cost of medical care" and, enough has been spent in the collection, analysis, and study of data and dissemination of conclusions to relieve much of the evil which it was intended to correct. Truly the cost of medical care has ascended, but what has not? Not only have the necessities of life enhanced in price, but the improvement in living has transferred last year's luxuries into the class of necessities, so that providence and thrift are fast disappearing virtues. A study of data, and broadcasting of results of the high cost of installment purchasing would do much if seriously received, to solve the question of the high cost of medical care.

In the past few years, it has scarcely been possible to pick up a medical journal in which some phase of the subject is not discussed. Many of the projects might justly be entitled: "A plan to make thrift unnecessary"—"A scheme for the abandonment of personal providence"—"Personal responsibility and its evadence". Since some form of taxable reservoir is essential for the successful working of such schemes the result that would follow would be a universe in which none would be assured a comfortable future, except the mentally incompetent, the indigent and malefactors. These would be definitely provided for though their activities would be a bit circumscribed.

Throughout this agitation, the physicians of Ohio have kept their heads, and so far as I can learn are overwhelmingly in favor of the old plan of having the doctor selected by the patient, called by the patient, and paid by the patient.

How the patient shall bring about the last of these essentials is a matter which he must arrange. Many individuals have been foresighted



JOHN A. CALDWELL, M.D., F.A.C.S., CINCINNATI

President of the Ohio State Medical Association for the year 1934-1935

enough to prepare for this contingency by the purchase from dependable companies of health and accident insurance, based on sound actuarial experience and fortified with statistics similar to those secured on other hazards, such as fire, death, tornadoes, hail, etc.

LEGISLATION AND PUBLIC RELATIONS

The attempt to correct medical practice by legislation as is the fashion nowadays, to try to correct everything which is supposed to need correction, has brought about a state of mind in some of our members, which to my way of thinking, is not good. That is, the feeling that the way to combat adverse legislation is by an aggressive militant entrance into the political arena to make our influence felt by chastening and compulsion. In other words, form another bloc. While I would be the last to counsel supine acquiescence to measures which we do not approve, I feel that all that we have accomplished in the past has been by reason, persuasion, appeal and final conviction of those who oppose our views and, while more coercive measures would gain occasional victories, we would meet with defeats which in the long run would be expensive. The word "Doctor" originally meant a "teacher", which is, after all, the highest calling to which one may aspire. To add another bloc would be one more group added to those who harrass legislators, and each of which occasionally triumphs by exchanging its influence for something in which it has no interest. The pressure or trades which small groups exert or offer during legislative sessions have done much to develop the legislative invertebratism which is responsible for many of our laws which are futile or silly. It is highly important that our members take an active interest in their legislators, and, by friendly advance, persuasion and establishment of the justice and usefulness of their measures, convince them, rather than attempt to drive them.

In that fountain head of all political wisdom, Plato's Dialogues, is found this statement, in substance: "The price which one pays for giving no attention to public affairs is that he shall be governed by one who is inferior to himself".

DISTRIBUTION OF MEDICAL SERVICE

In the past few years, much worry has been felt over the fact that physicians have been gradually drifting away from rural communities and settling in the metropolitan areas leaving the more sparcely populated places to be cared for by men who were settled and could not well leave. This trend has at times left communities with inadequate medical service and has been the cause of some uneasiness and worry on the part of those interested in medical economics. In 1924 Dr. William Pusey was president of the American Medical Association and he brought to this position a long experience with medical problems and a desire and studious effort to help in their solution. He found that in several states the average of physicians in rural communities ranged from 50 to 54 years, and he suggested as a remedy, that a shorter course, a sub-standard medical education of three years be given, licensing the holders of such sub-standard degrees to limited medical practice. This plan never received wide approval and now, 10 years later there are signs that the problem is being solved by more natural conditions. Good roads and the automobile have made the smallest hamlet accessible, and the radio and talking pictures have done much to relieve the seclusion of rural life. Then, while rural life has been made more attractive, the industrial stagnation and unemployment in cities has been particularly hard on the young, unestablished physician, and he has begun to discover that the small town while it has limitations in the way of diversions, has decided advantages in the way of lessened expense, and opportunities for service. Consequently in the past five years there has been a greater movement of young physicians to villages and small towns. To make sure that this was not pure assumption on my part I gathered the following statistical information. The source was the American medical directories of 1925, 1929 and 1934. In 1924 there were 623 towns in Ohio with population of less than 2,000 and their total population was 364,360. These towns and villages were served by 1,191 physicians whose average age was 50.6 years. In 1929 there were 1,159 physicians in those same towns and their average age was 58.6 years. During the five-year period from 1924 to 1929 there were only 48 recent graduates settled in these towns. In 1934 there was 1,151 physicians in these communities and the average of their ages was 53.2 years. But during this five-year period from 1929 to 1934, 178 recent graduates have moved in. My visits as Councilor to medical society meetings in rural counties had shown that in that district "a back to the country move" was taking place, and this data just quoted has shown that the move was not a local one. It would seem then that changes in economic conditions and modes of life are gradually solving the problem of medical care in rural communities without any radical change in medical training or curriculum.

HOSPITALS AND HOSPITAL SERVICE

The gradual replacement of medical men of former generations with young graduates who are familiar with the necessities and uses of modern scientific advances in methods of diagnosis and treatment is certain to cause these younger men to demand for their patients the facilities with which they are accustomed to work. As soon as any de-

mand becomes sufficiently acute and pressing it is bound to be followed by some attempt to supply that demand. I look for considerable multiplication of the small town and county hospital as well as privately-owned and operated institutions, and there has been some increase in these in the past 10 years. In 1924 there were 45 general hospitals in Ohio with less than 20 beds. In 1929 this number had increased to 55. In 1934 this number had shrunk to 51. It seems to me rather remarkable that only four failed to survive the depression. Undoubtedly the multiplication of the small hospital is fraught with the possibility for great service to the community which it serves, but it is also apt to cause much grief and blunting of conscience to those who conduct it. One who establishes a hospital soon learns that intangible factor known as "overhead" is going on every hour of the day whether the institution has two or 20 beds occupied, and that coal bills, water bills, nurses' and employes' salaries must be paid whether there are patients occupying beds or not. When there are not enough patients to carry the institution through there is a tendency to sell to those patients who do patronize the hospital, service which is unnecessary. This can easily be done by multiplying *X*-ray, laboratory, and various impressive forms of physiotherapy, to the profit of the hospital and sometimes of no benefit to the patient. The value of these services to the patient are usually weighed carefully by the physician to whom they mean no profit. But there is nothing so dulling to the sharp edge of conscience as a deficit, and it takes rather unusual qualities to withstand its importunities.

RECOGNITION AND CERTIFICATION OF SPECIALISTS

The increase in hospital facilities and consequent increase in surgery done in them has to my mind placed on the medical profession a new obligation of duty to the public. At present there is nothing to prevent anyone with a license to practice from doing any surgical operation he cares to undertake, except the conscience of the physician or the rules of a hospital. It would seem that it is a duty of organized medicine to give some certification of proficiency to those who set themselves up as particularly trained and qualified in some branch of the profession. The radiologists, ophthalmologists, laryngologists, and gynecologists have already taken steps to certify, after rigid investigation, those whom their investigation shows to be qualified. So far surgeons have not taken up this move except through the American College of Surgeons, and this organization has not up to the present time met the situation. I would not favor adding qualifications which would call for further licensure, for this would necessitate more machinery of enforcement and would certainly be followed by widespread evasion and violation of such a statute. A certification of proficiency with a wide dissemination of what this stands for places the responsibility for non-recognition of such a certified group squarely upon the ignorant or indifferent, and those who refuse to "forsake the foolish and live; and go in the way of understanding" may take the consequences. The American Medical Association has already taken steps for recognition and certification of those especially qualified and I would recommend that the Ohio State Medical Association do everything possible to further such a plan.

COMMITTEE ACTIVITIES

I have said nothing about the problems which have arisen involving the State Association with various state and federal departments, boards, bureaus, commissions, etc., especially the State Relief Commission and the State Industrial Commission, for the reason that you have active and efficient committees and an alert Council handling these matters and developments have from time to time been reported in *The Journal*. I am convinced all problems affecting the policy of the State Association have been most thoroughly dealt with and reported on by committees having them under special consideration and these committees have shown such industry in painstaking thoroughness that they are entitled to your gratitude.

We have before us another legislative year in which we will have to oppose legislation inimicable to the public good, and in which physicians only can show this incompatability. In this I bespeak your support, and, stimulated with the sense of my obligation, my interest in the welfare of the profession, and with the example of those who have gone before, I have no fear that the year will be one of retrogression.

— OSMJ —

Dr. Bachmeyer to Direct Clinics at University of Chicago

Effective January 1, 1935, Dr. Arthur C. Bachmeyer, superintendent of the Cincinnati General Hospital and former dean of the College of Medicine, University of Cincinnati, will become director of clinics, University of Chicago. In his new position, Dr. Bachmeyer will have the status of professor of medicine and assistant dean of the School of Medicine and will have charge of administration of three hospitals and three allied institutions. He succeeds Dr. Henry S. Houghton who resigned to return to China as advisory representative of the China Medical Board.

— OSMJ —

Second annual Institute on Cardio-Vascular Disease, sponsored by the Academy of Medicine and the Heart Council of Cincinnati, was held on October 29 at the Cincinnati General Hospital. Material dealing with the different phases of circulatory disorder was presented by the medical, pediatric and pathology departments.

TORSION OF THE GREAT OMENTUM ASSOCIATED WITH SUBACUTE APPENDICITIS

By ROBERT B. POLING, M.D.,

YOUNGSTOWN, OHIO

PIERRE DE MARCHETTIS reported the first case of torsion of the great omentum in 1851. Corner and Pinches, in 1905, collected fifty-four cases. From 1905 to 1929, 167 additional cases were reported making a total of 217 cases. The first full description of torsion of the great omentum was written by Oberst in 1882. Hochenegg wrote a full treatise in 1900.

Dr. John H. Morris made a comprehensive study of the subject as reported in the January, 1932, number of Archives of Surgery. The salient features of torsion of the omentum are summarized in this article as follows:

1. The normal environment and anatomic arrangement of the great omentum are such as to favor rotation of this structure about its long axis, while the introduction of certain mechanical conditions and pathologic changes within and adjacent to it supply the immediate exciting causes of such rotation.

2. It is clearly established that omental twists are capable of producing clinical symptoms of an acute and chronic character, and that this condition therefore merits some consideration in the diagnosis of abdominal conditions.

3. Variation in the intensity of degree of rotation determines two basic clinical and anatomic types of torsion: (1) the complete, in which acute, progressive symptoms and marked circulatory obstruction at the site of the twist, and (2) the incomplete which is characterized by vague, chronic recurring symptoms and mild pathologic changes in consequence of incomplete, partial or temporary obstruction which permits repeated spontaneous restitution before pronounced organic changes develop.

4. Diagnosis presents obvious difficulties as indicated by the fact that a correct preoperative diagnosis was recorded in only 7.9 per cent of 217 cases. A statistical report of the series, however, emphasizes certain essential clinical manifestations and points of history, the recognition of which should enhance the precision of a preoperative diagnosis.

5. The deliberate fixation of the free margin of the omentum by suture to an adjacent structure may be the source of future complications and its accidental inclusion during abdominal closure is to be avoided carefully.

Pathologist, St. Elizabeth Hospital.

CASE REPORT

P. M., male, aged 30 years, electrician, was seized with a sudden but severe abdominal pain while eating his dinner. It is said that he turned pale and felt faint. This lasted but a short duration of time after which he was better. During the afternoon he did not feel well and retired as soon as possible in the evening. He thought that he was having gas pains and took a laxative for relief. He spent a restless night accompanied by abdominal distress. Early in the morning the condition became sufficiently severe for him to call for medical aid.

A history of abdominal distress on previous occasions was obtained. These were not frequent or severe. Two years ago patient was seized by a pain in the region of the external abdominal ring and a diagnosis of beginning of inguinal hernia was made. A truss has been used ever since with no further trouble.

He had some of the usual childhood diseases and always recovered without complications.

Physical examination at 8:30 a. m. showed a temperature of 98° F., pulse 80, blood pressure 130-80. Head region, neck, heart and lungs did not give evidence of pathological change. The abdomen showed marked tenderness of the right upper quadrant, umbilical region and at McBurney's point on deep pressure. There was rigidity of the upper half of the abdominal musculature on the right side. The left side of the abdomen was free from tenderness and rigidity. At 2:00 p. m. temperature was 98.6° F., pulse 86, leucocyte count 8,400. Tenderness and rigidity of the right hypochondrium and umbilical region was increased. The lower part of the right side was soft but tender with deep pressure. At 4:00 p. m. the above symptoms and signs were increased and the patient felt worse. Temperature 99° F. There was complaint of increased abdominal distress.

Dr. J. M. Ranz was called in for surgical consultation. After further analysis of the case a diagnosis of acute appendicitis was considered correct and the patient was advised to submit to a laparotomy. This was done at 8:30 p. m. the same day.

A right rectus incision was made. Immediately on dividing the peritoneum it was found that the peritoneal cavity contained blood tinged fluid. On further investigation a mass was observed just under the anterior abdominal wall. It was the greater omentum twisted two and one-half turns causing strangulation of the mesenteric blood vessels. This was resected and the appendix removed.

The pathological examination revealed a mass 11 by 7 by 3 cm. Reddish gray. Tissue was folded on itself and the basal portion was twisted. Tissue was hemorrhagic and surface studded with lobules of fat. The omental apron was thick and firm. One portion gives the consistency of liver. Section shows the space between the layers of mesothelium filled with clots of blood. The blood vessels were thrombosed.

Microscopical examination presented the usual structure of omental tissue. It was markedly

congested and there was moderate leucocytic infiltration.

The appendix was 6 by 7 cm. Reddish gray, serosa injected. On section the wall was edematous and lumen contained blood. Mucosa was congested.

Microscopical examination showed the mucous membrane moderately inflamed and contained numerous eosinophiles. Submucosa and subserosa were inflamed. Miliary abscesses were noted. Muscular bundles were separated by a chronic inflammatory reaction.

The pathological diagnosis was torsion of the omentum and subacute appendicitis.

The patient made an uneventfuly recovery and is well at the present time.

2218 Market St.

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— OSMJ —

A Case of Probable Traumatic Thrombo-Phlebitis of the Axillary and Brachial Veins

By MAURICE H. GROSSBERG, M.D., and S. O. FREEDLANDER, M.D.,
CLEVELAND, OHIO

B. G., white male, age 25, a foundry worker, reported April 17, 1933, complaining of a swollen left arm, which he first noticed a few days previously. Due to slack conditions of employment he had not worked since April 5, 1933. On this last day shortly before quitting time he had loaded two wheelbarrows each up to 700 pounds, wheeled them 100 yards and dumped the load. Because of the press of time he did this work at top speed. A few hours after quitting time he felt a kink or cramp over the inner anterior aspect of the left elbow. This cramp persisted. The patient attempted to work it out by various exercises, e.g., on a rowing machine.

Examination revealed a powerfully built young male of 25 years. Temperature and pulse were normal. The left upper extremity was uniformly enlarged, to a distinctly greater size than the right. It was markedly cyanotic, the cyanosis having a sharp line of demarcation two inches proximal to the humeral insertion of the deltoid. On the axillary portion of the arm was a small, rounded swelling, non-tender, not pulsating, easily collapsed on pressure, and filling out again promptly on release of pressure.

There was slight tenderness over the volar aspect of the inner humeral condyle. A cord-like thickening was palpable in the course of the brachial vein. There was increased prominence of the subcutaneous veins over the outer aspect of the arm and over the left pectoral area. The superficial veins on the inner side of the left forearm were collapsed and empty. The rest of the physical examination was negative. A diagnosis was made of thrombo-phlebitis of the left axillary and brachial veins.

TREATMENT AND PROGRESS

The patient was put to bed. The left upper extremity was kept at right angles to the trunk, comfortably supported on a pillow. Heat was applied over the thrombosed vein.

On April 23, the patient complained of pain in the left axilla, also of pain and "stiffness" in the root of the neck on the left side. At this time the collapsible axillary swelling first noted had disappeared, and there was considerable tenderness at this site. The cyanosis began gradually to diminish in the distal two-thirds of the extremity, and the superficial veins of the arm and left pectoral area became more conspicuous.

After two weeks the patient was permitted up with the arm in a sling. He was allowed to resume his work by gradual stages beginning June 1.

Examination on July 27 revealed a slight degree of cyanosis still present. The patient states that the arm swells slightly and feels "tight" when he uses it. Measurement revealed that the affected arm was one centimeter larger in diameter than the other at corresponding levels.

COMMENT

The patient had no fever at any time and examination revealed no foci of infection. The following is suggested as a possible explanation of the origin of this thrombo-phlebitis: The straining in connection with lifting and moving unusually heavy loads caused a considerable increase of pressure in the systemic veins. Overdistension of the brachial veins was favored by persistent powerful contraction of the arm and forearm muscles forcing blood out of the numerous venous courses in these structures and tending to overfill the larger venous channels. A tear of the intima resulting from this overstretching would give rise to a traumatic thrombo-phlebitis.

10515 CARNEGIE AVENUE.

— OSMJ —

Township trustees are not obligated to pay for hospital and surgical services rendered a person who has not acquired a legal settlement in the State of Ohio, but such is an obligation of the county wherein such person is residing if the required notice is furnished the county commissioners of the county as required by law, according to an opinion rendered recently by Attorney General John W. Bricker.

— OSMJ —

The new research laboratories of the Eli Lilly and Company were formally dedicated on October 11 at Indianapolis with a series of formal dinners and programs, presented by some of the outstanding physicians and scientists of the country.

OFFICIAL PROCEEDINGS, HOUSE OF DELEGATES, OHIO STATE MEDICAL ASSOCIATION ANNUAL MEETING, COLUMBUS, OCT. 4, 5 AND 6, 1934

MINUTES

The 88th Annual Meeting of the Ohio State Medical Association convened officially in the Junior Ballroom, Neil House, Columbus, at 9:00 A. M. on Thursday, October 4, 1934. Dr. Verne A. Dodd, president of the Columbus Academy of Medicine, officially welcomed the Annual Meeting to Columbus. Following a few words of greeting, he expressed the hope that the meeting would be interesting and well attended, and that the activities of the local committees would be rewarded by success.

Dr. C. L. Cummer, the president of the State Association, was then presented and called the House of Delegates into official session.

The first order of business was the roll call showing 85 delegates and officers present, this being a majority of those registered and constituting a quorum under the Constitution. (See tabulation of roll call attendance on pages 752-753).

On *motion* by Dr. Jenkins, seconded by Dr. McCurdy and *carried*, the minutes of the House of Delegates of the 87th Annual Meeting held in Akron, September 7 and 8, 1933, were approved as published on pages 636 to 645, inclusive, of the October, 1933, issue of *The Journal*.

Attention was called by the President to the requirement that all resolutions to be introduced later in this session must be referred to the Committee on Resolutions for consideration by the committee and transmission to the House of Delegates at the Friday afternoon session, thus requiring that all resolutions to be considered at this Annual Meeting must be introduced at the present session. He also announced that all resolutions must be introduced in typewritten form, in duplicate, and signed by the author.

Annual Reports

Under the next order of business, President Cummer called for the annual reports of officers, standing committees and special committees. These were published in full in the October, 1934, issue of *The Journal* and were submitted, as published, for the consideration of the House of Delegates, these reports being:

Reports of Standing Committees:

(a) Public Policy—C. W. Stone, Cleveland, chairman, pages 658 to 663.

(b) Medical Economics—J. Craig Bowman, Upper Sandusky, chairman, pages 664 to 668.

(c) Publication—Andrews Rogers, Columbus, chairman, pages 668 to 670.

(d) Medical Defense—J. E. Tuckerman, Cleveland, chairman, pages 670 to 673.

(e) Medical Education and Hospitals—Ben R. McClellan, Xenia, chairman, pages 674 to 680.

(f) Auditing and Appropriations—B. J. Hein, Toledo, chairman, pages 684 to 686.

Reports of Special Committees:

(a) Preventive Medicine and Periodic Health Examinations—V. C. Rowland, Cleveland, chairman, pages 681 to 683.

(b) Military and Veterans' Affairs—Louis Feid, Jr., Cincinnati, chairman, pages 687 to 689.

Reports of Officers:

(a) Treasurer's report combined with report of Committee on Auditing and Appropriations, pages 684 to 686.

(b) Reports of Councilors as to the condition of the societies in their respective districts, pages 690 to 693.

President Cummer announced that all the foregoing reports were referred at this time without discussion to the Reference Committee on Annual Reports to be announced later at this session, for their consideration and report at the Friday (October 5) afternoon session of the House of Delegates.

Appointment of House of Delegates Committees

The President announced the appointment of reference and active committees of the House of Delegates as follows:

Annual Addresses of the President and President-Elect—Carl R. Steinke, Akron, chairman; R. R. Hendershott, Tiffin; A. G. Ray, Jackson; J. D. Boylan, Milford Center; R. B. Wynkoop, Ashtabula.

Annual Reports of Standing and Special Committees—Otto J. Seibert, Cincinnati, chairman; Guy Noble, St. Marys; John F. Wright, Toledo; R. C. Paul, Wooster; C. S. McDougall, Athens.

Resolutions—E. J. Emerick, Columbus, chairman; D. C. Houser, Urbana; C. W. Kirkland, Bellaire; F. S. Gibson, Cleveland; J. C. Larkin, Hillsboro.

Credentials of Delegates—V. N. Marsh, Painesville, chairman; D. W. Hogue, Springfield; Sidney McCurdy, Youngstown; Mary Austin, Gallipolis; Ray Vaughen, West Union.

Tellers and Judges of Election—D. J. Slosser, Defiance, chairman; Robert T. Leever, Waverly;

Roland Good, Van Wert; Ralph Smith, Lancaster; S. A. Harris, Steubenville.

Election of Nominating Committee

Under provisions of the Constitution for the selection of members of the Nominating Committee, one from each of the ten Councilor districts, the following personnel of such committee was *nominated* and duly *elected:*

First District—J. V. Greenebaum, Cincinnati, nominated by Dr. Seibert.

Second District—D. W. Hogue, Springfield, nominated by Dr. Dutrow.

Third District—E. L. Brady, Marion, nominated by Dr. Good.

Fourth District—John F. Wright, Toledo, nominated by Dr. Lukens.

Fifth District—H. V. Paryzek, Cleveland, nominated by Dr. Tuckerman.

Sixth District—F. C. Potter, Akron, nominated by Dr. DeWitt.

Seventh District—S. A. Harris, Steubenville, nominated by Dr. Sackett.

Eighth District—Emmett A. Moore, Newark, nominated by Dr. Swan.

Ninth District—A. G. Ray, Jackson, nominated by Dr. Micklethwaite.

Tenth District—J. M. Thomas, Columbus, nominated by Dr. Upham.

On *motion* duly seconded and *carried*, the House of Delegates *elected* by acclamation each of the above members nominated for the Nominating Committee.

President Cummer then announced the official personnel of the Nominating Committee as elected by the House of Delegates, as follows:

First District—J. V. Greenebaum,
Second District—D. W. Hogue,
Third District—E. L. Brady,
Fourth District—John F. Wright,
Fifth District—H. V. Paryzek,
Sixth District—F. C. Potter,
Seventh District—S. A. Harris,
Eighth District—Emmett A. Moore,
Ninth District—A. G. Ray,
Tenth District—J. M. Thomas.

Nominations to be Made

The President issued instructions to the Nominating Committee, under the constitutional provisions, and requested them to meet and decide upon one nominee for each of the offices to be filled at this Annual Meeting, except for the office of president-elect, which latter office is to be upon nomination on the floor of the House of Delegates at the Friday afternoon session.

Introduction of Resolutions

Under the next order of business, President Cummer called for the introduction of resolutions. The following resolutions were then introduced, and under constitutional provision were referred to the Committee on Resolutions for consideration and report at the second session of the House of Delegates on Friday afternoon, October 5.

RESOLUTION A. INTRODUCED BY H. C. KING, CLEVELAND:

WHEREAS, In February of this year, Don K. Martin, Esq., completed fifteen years of service to this Association; and,

WHEREAS, He has given to the Association his best efforts and has served it with unusual faithfulness and ability; and,

WHEREAS, He has shown in the fulfillment of his duties singular devotion, excellent judgment, and deep appreciation of the ideals and traditions of the medical profession; and,

WHEREAS, It is appropriate that this fifteenth anniversary be commemorated by some recognition of his service, therefore, be it

RESOLVED, By the House of Delegates of the Ohio State Medical Association in annual session assembled in the city of Columbus that the thanks of the Association be extended to him for his sincere interest, his loyalty, and his fidelity to its interests and those of its members.

RESOLUTION B. INTRODUCED BY CARL R. STEINKE, AKRON:

WHEREAS, There is in Ohio state-wide activity to bring about changes in local government machinery, to remedy duplication and overlapping and eliminate financial waste, in line with procedure approved by the electorate in adoption of a constitutional amendment in the Fall of 1933, and

WHEREAS, This question of governmental reorganization undoubtedly will come before the voters of many counties in the near future, be it

RESOLVED, That the House of Delegates, assembled in Columbus, October 4 and 5, 1934, recommends that physicians, as citizens and taxpayers, take a keen and active interest in proposals involving changes in the set-ups and functions of government, both state and local. Simplification in government and reorganization on a scale that will distinguish between essentials and non-essentials are questions which should be of vital concern to every physician. Moreover, physicians are obligated to analyze such proposals from the standpoint of their possible effect on public health administration must be maintained throughout Ohio on an adequate and sound basis not be modified so as to become ineffective and merely an incidental or secondary function of government, if the interests of the public are to be safeguarded.

RESOLUTION C. INTRODUCED BY J. H. J. UPHAM, COLUMBUS:

WHEREAS, It is vital that the Ohio Workmen's Compensation System be maintained on a sound and efficient basis, and

WHEREAS, The medical profesison of Ohio is sincerely concerned in effective and equitable administration of the Workmen's Compensation Law and in the preservation and use of the compensation fund for purposes for which it is intended, and

WHEREAS, Constructive efforts now are being made to strengthen the structure of the Ohio Workmen's Compensation System; improve its administration, and eliminate abuses of the fund; therefore, be it

RESOLVED, That organized medicine in Ohio through this House of Delegates of the Ohio State Medical Association, assembled in Columbus, Ohio, October 4, 5 and 6, 1934:

1. Pledges its wholehearted and active support to the State Industrial Commission, the Governor's Investigating Committee on Workmen's Compensation, and other organizations and groups sincerely and directly concerned with the underlying principles of workmen's compensation and who are attempting to bring about constructive changes in the Ohio Workmen's Compensation Law and its administration.
2. Endorses and approves the recommendations and suggestions made by the Special Workmen's Compensation Committee of the Ohio State Medical Association to the State Industrial Commission and the Governor's Investigating Committee for improvements in the Workmen's Compensation System and urges all or any of those recommendations be put into effect as soon as possible.
3. Expresses appreciation for the faithful and efficient activities of the Special Workmen's Compensation Committee of the State Medical Association in representing so effectively the interests of the entire medical profesison before the Industrial Commission and the Governor's Investigating Committee.
4. Condemns the actions of claimants, employers, physicians, or others, guilty of abuses and dishonest dealings with the State Industrial Commission and approves of efforts under way to safeguard the compensation fund from such abuses and to discipline guilty individuals.
5. Offers its active and organized assistance to efforts to secure for the Industrial Commission adequate annual appropriations from the General Assembly so that its administrative machinery may function effectively and be strengthened and improved.

RESOLUTION D. INTRODUCED BY DREW L. DAVIES, COLUMBUS:

WHEREAS, In many counties of the state, physicians are being paid nothing or ridiculously inadequate fees on a pro rata basis for services rendered by them to indigents and the temporarily unemployed, and

WHEREAS, In most of the counties where this situation prevails, the local relief director is primarily to blame because of his failure to budget each month the maximum sum available for medical service to those on relief under Rules and Regulations No. 7, FERA, or because he has used such funds, when allotted by the State Relief Commission, for other relief work; therefore, be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association protest this unfair, unsympathetic and shortsighted attitude on the part of some county relief directors, and, be it further

RESOLVED, We recommend to the county medical societies or academies of medicine in counties where this condition exists, that they, if they have not already done so, arrange for conferences with the officials of their local relief administration; emphasize to them the desirability and necessity of more thorough consideration of local medical needs under the relief plan; request that funds within the maximum allowance of the State Relief Commisison be budgeted and used for medical services, and ask for the appointment of a local medical advisory committee from among the membership of the society or academy to assist the relief administration with medical questions and serve as a contact medium between the relief director and the local medical profession.

RESOLUTION E. INTRODUCED BY SIDNEY MCCURDY, YOUNGSTOWN:

A Resolution prepared by the Economics and Legislation Committees and indorsed by the Council of the Mahoning County Medical Society with instructions to the Delegates of the Mahoning County Medical Society to present the same to the House of Delegates of the Ohio State Medical Association at the 88th Annual Session in Columbus, Ohio, 1934.

RESOLUTION

WHEREAS, We of the Ohio State Medical Association, believe that the care of the indigent sick and disabled is the responsibility of society at large and not the care of any one group of society: and

WHEREAS, The laws of Ohio which provide for the care of the sick, indigent, and poor relief, are in part antiquated and inefficient:

BE IT RESOLVED, That we approve and indorse the proposed bill, initiated by the Ohio Hospital Association, amending and correcting those parts of the General Code which are deemed antiquated and inefficient, as set forth in the following summary:

The purpose of this proposed bill is to centralize all health problems, providing medical and surgical care and hospitalization. For the indigent persons, under one head, the "Health Commissioner." At the present time this responsibility rests with the Poor Authorities, County Commissioners, Township Trustees and Infirmary Directors. This bill proposes to make it mandatory on the Health Commissioner to furnish hospitalization, and to authorize the Health Commissioner to enter into contracts with hospitals to furnish this care at a certain rate.

The present poor and health laws are so closely interwoven it will be necessary to amend twelve sections of the General Code, write six new sections and repeal five sections to accomplish our purpose.

BE IT FURTHER RESOLVED, That we cause to be written into the proposed bill, sections and clauses necessary to provide remuneration by the constituent Health units of Ohio, to physicians for the medical and surgical care of the indigent sick and disabled, as defined in the proposed bills or present a new and separate bill providing such remuneration; all consistent with the Principles of Medical Ethics, and providing for free choice of physician.

BE IT FURTHER RESOLVED, That in the event of reenactment of the auto accident bill (House bill No. 80) reimbursement to physicians for care of such cases be included in the proposed bill.

AND, BE IT FURTHER RESOLVED, That this proposed legislation be referred to the Committee on Public Policy for action.

RESOLUTION F. INTRODUCED BY OTTO J. SEIBERT, CINCINNATI:

WHEREAS, Powerful forces and agencies are attempting to bring about in this country radical

changes in the delivery of medical service and the relations between physician and patient, and

WHEREAS, It is of vital importance that the policy of organized medicine toward such experiments now under way, or advocated, be clearly and definitely understood by both the public and the members of the medical profession, and

WHEREAS, It is essential that the medical profession stand united on policies and principles relating to scientific medicine, public health and medical practice,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association, representing the overwhelming majority of physicians of Ohio, re-emphasizes and re-affirms the established policy of organized medicine toward changes in the nature of medical practice as follows:

We favor and actively support changes in the nature of medical practice which are basically sound, are practical and necessary, are in the interests of the public, and in accord with sound public policy.

We favor and encourage experiments in providing medical service to the public which are properly controlled and based on sound social, economic and medical principles.

We condemn as detrimental to public interest and scientific medicine and vigorously oppose experiments, schemes, programs or proposals involving changes in the present scheme of medical service and medical practice which violate any of the principles unanimously adopted by the House of Delegates of the American Medical Association on June 12, 1934, at Cleveland, Ohio, and published as a part of the official minutes in the June 30, 1934, issue of *The Journal of the American Medical Association*, pages 2199 and 2200.

We are firmly convinced that comparatively few changes in methods of administering medical care are necessary and the standards of medical care in this country are higher than those in any other nation, which standards can be maintained only through forms of medical practice which preserve the personal relationships between physician and patient, maintain the practice of medicine as a profession, eliminate the interests of the commercial promoter and third-party whoever he may be, insure the free choice of physician by the individual patient, keep medical service and cash benefits distinct and separate, demand observance of the Principles of Medical Ethics on the part of medical practitioners, and are in accord with sound and proven social and economic principles.

RESOLUTION G. INTRODUCED BY D. M. GLOVER, CLEVELAND:

WHEREAS, One of the fundamental purposes of medical organization is to promote the science and art of medicine and disseminate medical knowledge among the members of the medical profession; and

WHEREAS, The presentation of stimulating and instructive discussions at county medical society meetings is one of the most effective methods of promoting the continuous education of the physician; and

WHEREAS, Experience has shown that frequent participation by local physicians in scientific programs presented before their local medical society is an essential factor in keeping the membership of the society keyed to a high pitch of interest, enthusiasm and efficiency; be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association, in session October 4 and 5, 1934, Columbus, Ohio, earnestly urges each component county medical society or academy of medicine to give this important question its serious consideration and put forth during the ensuing year special efforts to enhance the value of its scientific activities.

We especially recommend that the officers and program committee of each county society or academy of medicine, if they have not already done so, acquaint themselves with and analyze carefully the "study outline" plan for county society programs. The merits and advantages of this and similar ideas for stimulating scientific activities were well summarized by Dr. C. L. Cummer on his President's Page published in the August, 1934, issue of *The Journal*, and under whose direction a number of suggested "study outlines" have been prepared and are being published in *The Journal*. The outlines prepared for the *Journal*, we believe can easily be adapted to meet the program requirements of any county society or academy and it is our hope that the plan will be given an early trial by a large number of societies.

RESOLUTION H. INTRODUCED BY JOHN P. DEWITT, CANTON:

WHEREAS, Heavy demands have been made upon the officers, Councilors, committees and headquarters staff of the State Association during the past 12 months in representing and protecting the interests of the medical profession in public matters, because of the material increase in the number and importance of social, economic, governmental, and legislative problems affecting scientific medicine, public health and medical practice, and the necessity for medical organization to assume greater responsibilities in seeing that the consistent, sound, conservative and concerted medical viewpoint on such questions is expressed and emphasized, be it

RESOLVED, By the House of Delegates of the Ohio State Medical Association in 88th annual meeting at Columbus, October 4, 5 and 6, 1934, that appreciation and approval be expressed to the officers, Councilors and committees of this association for their faithful and meritorious activities during the past year; to our executive staff for effective and devoted services in the interests of the profession and in promotion of the aims and purposes of organized medicine, and be it further

RESOLVED, That appreciation be expressed to those officers, committeemen and other members of the component county medical societies and academies of medicine who have cooperated to the fullest extent in the activities of our State Association. Through their help and assistance many constructive things have been accomplished for the good of the profession as a whole. Their continued support and active interest are essential to the concerted, organized efforts which we must put forth during the ensuing year.

RESOLUTION I. INTRODUCED BY THEODORE MILLER, CLEVELAND:

WHEREAS, Statistical data show that a considerable number of deaths of women during pregnancy, labor, or following childbirth in Ohio annually could be prevented if all prospective

mothers would avail themselves of competent medical care during pregnancy; and

WHEREAS, An active campaign has been launched in the state by obstetricians, in cooperation with official public health departments, to promote greater public interest in the value and benefits of prompt and adequate prenatal care for expectant mothers by their family physicians;

BE IT RESOLVED, That this House of Delegates urges and recommends all members of the State Association to give their active cooperation and assistance to this movement by emphasizing to their individual patients the importance of early and competent medical care for pregnant women and by being prepared to render such service as a part of their daily practice.

RESOLUTION J. INTRODUCED BY HENRY B. FREIBERG, CINCINNATI:

WHEREAS, Great responsibilities rest with the medical schools of the country in assisting the medical profession to meet the needs of and function effectively in an ever-changing social order, be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association this 4th day of October, 1934:

Solicits the continued cooperation and assistance of Ohio's three Class A medical schools in efforts of organized medicine in Ohio to meet problems having an important bearing on the medical practice of the future;

Commends the medical schools of Western Reserve University, University of Cincinnati, and Ohio State University, for their activities over a long period of years, which have won for them high standing among the medical schools of the nation;

Urges them to give special consideration to the part the medical school should take in organized medicine's efforts to keep the supply of physicians reasonably near the number required to provide competent medical service; to institute such regulations or requirements that shall prevent overcrowding in the profession; correct, if possible, the uneven distribution of physicians; expand post-graduate opportunities for physicians in active practice; remedy unsatisfactory conditions resulting from over-crowding and lack of uniform standards in the specialties; keep the profession informed regarding the social aspects of medical practice and prepared to quickly adjust itself to changing social and economic conditions; stimulate in all physicians a devotion to the Principles of Medical Ethics and high scientific and moral standards; and, encourage membership and active interest in medical organization with special emphasis on the advantages, benefits and importance of concerted, organized activity;

Pledges the assistance of organized medicine in the preservation of the high standards attained by medical education in Ohio and the maintenance of adequate facilities so that medical students in Ohio may obtain the best possible training and instruction.

RESOLUTION K. INTRODUCED BY GEO. L. SACKETT, NEW PHILADELPHIA:

K. 1

WHEREAS, The Tuscarawas County Medical Society, by motion duly passed on the 13th day of September, 1934, has authorized the appointment of a committee to draft Resolutions to be presented to the House of Delegates of the Ohio State Medical Society, and,

WHEREAS, a special committee consisting of the undersigned members was duly appointed to formulate said Resolution.

NOW THEREFORE, Be it resolved by said Committee.

Section 1:—

That the House of Delegates be and is hereby requested to appoint a special committee to investigate and to report to the Council of the Ohio State Medical Society as soon as said investigation may be completed.

Section 2:—

That said investigation shall be a critical review of the relations of the Ohio State Medical Association with all branches of state welfare and indigent relief in order to obtain more effective supervision of the medical phases of these departments by the medical profession.

Section 3:—

That said special committee, after investigation and report to the Council, be authorized to act as a contact committee for the medical profession in Ohio, and that said committee be empowered promptly to deal and cooperate with the state welfare and indigent relief agencies on all medical aspects and current problems of relief in this State.

Section 4:—

That the Resolution Committee of the House of Delegates be and is hereby requested to grant proponents of this Resolution, a hearing on the same.

Section 5:—

That a copy of this Resolution be certified to the Resolution Committee of the House of Delegates.

K. 2

WHEREAS, The Tuscarawas County Medical Society, by motion duly passed on the 13th day of September, 1934, has authorized the appointment of a committee to draft Resolutions to be presented to the House of Delegates of the Ohio State Medical Society, and,

WHEREAS, a special committee consisting of the undersigned members was duly appointed to formulate said Resolution.

NOW THEREFORE, Be it resolved by said Committee.

Section 1:—

That it is against the interest of the State Medical Society to devote space in the Medical Journal to the editorial expression of partisan opinion concerning social-political problems not directly pertaining to the practice or science of medicine.

Section 2:—

That the House of Delegates be and is hereby requested to instruct the Committee on Public Policy to register and communicate its disapproval of the aforementioned editorial practice.

Section 3:—

That the Resolutions Committee of the House of Delegates be and it is hereby requested to grant proponents of this resolution, a hearing on the same.

Section 4:—

That a copy of this Resolution be duly certified to the Resolutions Committee of the House of Delegates.

K. 3

WHEREAS, The Tuscarawas County Medical Society, by motion duly passed on the 13th day of September, 1934, has authorized the appointment of a committee to draft Resolutions to be presented to the House of Delegates of the Ohio State Medical Society, and,

WHEREAS, a special committee, consisting of the undersigned members was duly appointed to formulate said Resolution.

WHEREAS, The income of Physicians of the State has greatly diminished during the past four years, and,

WHEREAS, The operating expenses of the Society exceeded the income from membership dues, and,

WHEREAS, The salaries of Executive Secretary, and Assistant, and their expenses account totaled $11,325.00, said sum being approximately one-half of the income from dues for the past fiscal year.

NOW THEREFORE, Be it resolved by said committee.

Section 1:—

That the Committee on Auditing and Appropriations be instructed to revise their budget downward in conformity with the present economic conditions.

Section 2:—

That a copy of this Resolution be certified to the Resolutions Committee of the House of Delegates.

Miscellaneous Business

Announcements were made by the chairmen of the various reference committees of the time and meeting places for meetings of their respective committees in order that members of the House of Delegates and other members interested in matters referred to such committees, might appear at such meetings.

Additional business being called for and none being presented, the House of Delegates adjourned to meet in the Junior Ballroom, Neil House, at 3:30 P. M. on the following day, Friday, October 5, 1934.

SECOND SESSION

The second and final session of the House of Delegates during the 88th Annual Meeting was called to order by President Cummer at 3:30 P. M., Friday, October 5, 1934, in the Junior Ballroom, Neil House.

Responses to the roll call showed 96 delegates and officers present. (See pages 752-753.)

There having been no unfinished business from the first session of the House of Delegates, the President called for the next order of business.

Annual Election

Under the next order of business, nominations from the floor for the office of president-elect were called for, and the following nominations were made:

R. R. Hendershott, Tiffin, nominated by J. Craig Bowman, and the nomination seconded by John F. Wright.

E. M. Huston, Dayton, nominated by H. V. Dutrow, and the nomination seconded by D. W. Hogue.

Further nominations being called for and none being presented, on *motion* by Dr. DeWitt, seconded and *carried*, the nominations were closed and the Committee of Tellers and Judges of Election were requested by the President to distribute ballots.

The result of the ballots being tabulated and announced showed the following:

Dr. Hendershott, 66.
Dr. Huston, 21.

On the basis of the above result, the President declared Dr. Hendershott officially elected as President-elect of the State Association.

Election of Treasurer

The Nominating Committee, through Dr. Greenebaum, the chairman, announced the nomination of James A. Beer, Columbus, for re-election as treasurer for a term of three years.

There being no further nominatoins from the floor, upon *motion* by Dr. Harris, seconded by Dr. Wright and *carried*, Dr. Beer's re-election was made unanimous by acclamation.

Election of Councilors

Under the next order of business, the Nominating Committee was requested to report through the chairman, Dr. Greenebaum, nominees for the office of Councilor from the First, Third, Fifth, Seventh and Ninth Districts.

First District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the First District:—Parke G. Smith, Cincinnati.

There being no further nominations from the floor, on *motion* by Dr. Freiberg, seconded by Dr. Seibert and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for Parke G. Smith, Cincinnati, for Councilor of the First District for the constitutional term of two years. So *recorded* and *announced.*

Third District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Third District:—O. P. Klotz, Findlay.

There being no further nominations from the floor, on *motion* by Dr. Tuckerman, seconded by Dr. Goodman and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for O. P. Klotz, Findlay, for Councilor of the Third District for the constitutional term of two years. So *recorded* and *announced.*

Fifth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Fifth District:—A. A. Jenkins, Cleveland.

There being no further nominations from the

floor, on *motion* by Dr. Stone, seconded by Dr. Upham and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for A. A. Jenkins, Cleveland, for Councilor of the Fifth District for the constitutional term of two years. So *recorded* and *announced*.

Seventh District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Seventh District:—Carl Goehring, Steubenville.

Further nominations being called for:

E. B. Shanley, New Philadelphia, was placed in nomination by Dr. Steinke, and the nomination was seconded by Dr. Ray.

C. W. Kirkland, Bellaire, was placed in nomination by Dr. Sackett, and the nomination was seconded by Dr. McCurdy.

There being no further nominations, on *motion* by Dr. Schriver, seconded by Dr. Upham and *carried*, the nominations were *closed*.

The President requested the Committee on Tellers and Judges of Election to distribute the ballots. These being tabulated showed the following result:

C. W. Kirkland, 51.
Carl Goehring, 15.
E. B. Shanley, 13.

As a result of the above ballots, President Cummer declared C. W. Kirkland, Bellaire, *elected* as Councilor from the Seventh District for the constitutional term of two years.

Ninth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Ninth District:—I. P. Seiler, Piketon.

There being no further nominations from the floor, on *motion* by Dr. McDougall, seconded by Dr. Harris and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for I. P. Seiler, Piketon, for Councilor of the Ninth District for the constitutional term of two years. So *recorded* and *announced*.

Election of A. M. A. Delegates

The Nominating Committee, through Dr. Greenebaum, chairman, announced the nomination of the following delegates and alternates to the American Medical Association for a term of two years:

Wells Teachnor, Sr., Columbus, Delegate.
Carl R. Steinke, Akron, Alternate.
Ben R. McClellan, Xenia, Delegate.
A. C. Messenger, Xenia, Alternate.
E. R. Brush, Zanesville, Delegate.
G. Micklethwaite, Portsmouth, Alternate.
C. W. Stone, Cleveland, Delegate.
V. N. Marsh, Painesville, Alternate.

There being no nominations from the floor, on *motion* by Dr. Coe, seconded by Dr. Ray and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for the nominations as made by the Nominating Committee. So *recorded* and *announced*.

Introduction of New President-Elect

The President having appointed a committee to find and bring to the rostrum R. R. Hendershott, newly-elected president-elect, he was brought to the rostrum and introduced by President Cummer. Dr. Hendershott expressed appreciation for the honor extended to him. He stated that he was aware of the large responsibilities and that he hoped to be worthy as a successor to those who had immediately preceded him in office. He bespoke the united support of the membership.

Miscellaneous

Upon *motion* by Dr. Tuckerman, seconded by Dr. Paryzek and *carried*, the House of Delegates limited speakers, other than chairmen of reference committees, on any one subject to three minutes.

Reports of Reference Committees

Under the next order of business the reports of the various committees appointed by the President at the first session were called for.

Dr. Steinke, chairman of the Committee on the Annual Addresses of the President and President-elect, presented the following report:

Annual Addresses

The Address of Dr. John A. Caldwell.

Dr. Caldwell considers the economic and social problems of the medical profession in an intelligent and understanding manner. The fact is pointed out that those financing and encouraging the study of the "high cost of medical care" are not those vitally concerned in the care of the sick and disabled, but people having accumulated wealth are seeking methods of gratifying their lust for greater power and self-satisfaction.

The thought of urging personal thrift that people may take care of the expense of their own medical needs is to be highly endorsed. The purchase, when possible, of health and accident insurance in dependable companies should be encouraged.

Each county society should note, especially, the consideration on legislation and public relations and become more active in obtaining representation favorable to our cause. It may become necessary to be militant on state and federal relief problems relating to medical care. Dr. Caldwell expresses the best sentiment of the medical profession in this problem, but your committee believes that without formation of a bloc there can and should be the development of a vigorous demand for the participation of the medical profession in the formulation of all relief programs in which medical service has a part. It is recognized that the state organization has had remarkable success in bringing about solution of difficulties as they arise, but the committee believes that medical leadership is essential in the formulation of relief programs. Therefore, the formation of a bloc may become imperative. The profession must become more interested in the relief situation.

Dr. Caldwell favors higher medical standards and he is to be commended for this. The distri-

bution of medical service to the rural communities, as shown in this address, is adjusting itself in such a way that no special action by the profession is needed.

The building of small hospitals is a local problem which should be limited to the general run of medical and surgical practice together with emergency work, and leave the higher technical procedures to large well-equipped hospitals and fully-qualified specialists.

The ideas expressed regarding the recognition and certification of specialists are to be heartily endorsed.

On the whole, the address is splendid and the committee highly commends Dr. Caldwell in his expressions and ideas.

On *motion* by Dr. Steinke, seconded by Dr. Goodman and *carried*, the House of Delegates *approved* this portion of the committe's report.

The Address of Dr. C. L. Cummer.

Dr. Cummer gives a short review of the beginning of our Association with its original objects, supplemented by added objects made necessary through changing medical conditions and conditions in general.

The high points in the year's activities are stressed. The work of the Council and the Public Policy Committee deserves special commendation for the energetic and successful handling of legislative measures presented during the last session of the Legislature.

Dr. Cummer made an unusually vigorous effort in attempting to deal with state and federal medical relief, together with obtaining higher fee schedules, but was unsuccessful in securing an audience with any of the Relief Commission. Through a conference with Governor George White he did obtain an increase in the fee schedule. There is evidently a lack of uniformity in payments in the various counties and this should be investigated. It is evident the lay head of relief in each county is more or less responsible for allocation of funds for medical care and, therefore, each county society or academy should look more closely into this matter.

The comments on group insurance are well taken and endorsed.

The committee congratulates Dr. Cummer and those instrumental in the progress made in the workmen's compensation developments and we trust this improvement will continue.

The remarks on medical education are very timely, especially the study outline courses recommended for use by the component county societies as published in recent issues of *The Journal. The Medical Journal* has been unusually good of late, and is recognized as outstanding among the state medical journals. It should be read by all our members.

The invaluable service of the Medical Defense Committee cannot be too highly commended for it saves the members more through its prevention of malpractice suits than the total expense account of the Ohio State Medical Association. Juries are giving large judgments in many states, so it behooves us to stand by this splendid committee in every way possible.

Each county society should maintain its identity by holding business sessions and enlarging social contacts of its members, thus creating a loyalty one to another. It may be not amiss for the small units to unite occasionally for concentrated educational programs.

Too much governmental interference with the doctor and his patient is to be deplored. The committee heartily approves the opinions expressed on the fundamentals of social service.

The cost of medical care is unusually well dealt with and should be studied by each member. Your committee would suggest that more publicity and propaganda be circulated through the state and county health departments and that care be taken not to extend their function into the care of the sick.

Dr. Cummer's consideration of socialized medicine is very timely and well thought out. He still would have the physician recognized through his art as well as his science. The sick cannot be properly dealt with in a wholesale manner, but by individualized consideration, sympathy and treatment. The five reasons given should be mentally digested by each member of our Association.

The challenges of today as portrayed deserve careful and conscientious treatment by the incoming President, the Council, the various committees and all the members.

We concur in the great appreciation of the services of Don K. Martin and his official staff.

The committee heartily endorses the timely and excellent address of Dr. Cummer.

(Signed) CARL R. STEINKE, *Chairman*,
R. R. HENDERSHOTT,
A. G. RAY,
J. D. BOYLAN,
R. B. WYNKOOP.

On *motion* by Dr. Steinke, seconded by Dr. Paryzek and *carried*, the House of Delegates *approved* this portion of the committee's report.

Annual Reports

TO THE HOUSE OF DELEGATES, OHIO STATE MEDICAL ASSOCIATION:

In these trying times of great financial depression and radical changes in our government, especially as it affects our social structure, and with a great number of new problems which have confronted the medical professon because of its relationship to both public and community life, it is very important that a strong and effective medical organization be not only maintained but correspondingly increased.

The success of the Ohio State Medical Association as every other organization of such an extent and importance, has rested upon the officers, the Councilors and the committees. However, complete success could have been possible only through the sustained support and cooperation of the membership at large.

While endeavoring at all times to base their policies and activities on the greatest good to the public, our Council and committees have adhered to the fundamental principle that anything which would be detrimental to scientific medicine and the medical profession would inevitably be detrimental to the public. Therefore, their concern on our behalf as practicing physicians has included thoughtful consideration for our economic security.

The functions and constant activities of the committees are summarized and briefly reflected in the annual reports published in the October issue of our *Journal* and which this reference committee of our House of Delegates has now had under consideration.

I. Annual Report of the *Committee on Medical Defense.*

The annual report of the Medical Defense Committee is clear, concise and practical. The defense at the disposal of the members of the State

Association is manifested in its two-fold purpose, timely, gratifying and applicable; its statistics are enlightening, complete and gratifying; its reference to the part played by uninterested physicians in suits brought against physicians, surgeons or clinics as appalling, disrespectful and indefensible is illuminating and merits serious consideration.

The information should appeal to every ethical member of the profession as a challenge for support and the maintenance of an organization that will not down.

II. Annual Report of the *Committee on Preventive Medicine and Periodic Health Examinations.*

The thorough, intelligent and systematic health examinations are essential in the diagnosis of any pathology. Naturally, following that assertion the competent physician or surgeon is in a position to advise, guide and direct the physiological.

Preventive medicine is to the future public what the mechanical engineer is to the industries of the nation.

The attention to the physiological is the key to the pathological and the latter so depends upon the former that they become so interlocked as to be inseparable.

The pediatric study or issue, the prenatal attention and the section on social diseases are paramount and should receive the most hearty, sincere and loyal support of the entire profession, and this will only be brought about by medical organization and a system of properly directed public information.

III. Annual Report of the *Committee on Medical Education and Hospitals.*

In its report, this committee has emphasized the errors of both hospitals and physicians brought about by the complete change in economic conditions, and has promulgated rules for *both*, the observance of which will go far to promote a mutual understanding of problems and an avoidance of an infringement on the rights of either group.

It has also called attention to the high rank held by Ohio's medical schools, and very ably brought forth the idea that the medical school administration should place more stress on the advantages of *organized medicine*, so that the young graduate will be conversant with the aims, problems and accomplishments of our organization.

IV. Annual Report of the *Council.*

It is interesting and encouraging to note that regardless of the present economic condition of our state and the nation, the membership of the Ohio State Medical Association has been increased during the year and this alone is sufficient evidence to prove the satisfactory and harmonious feeling of its more than 5,000 members.

The report of the Councilors, while brief, indicates that the membership of the Association is faithful to the original fundamental principles of organized and scientific medicine as set forth in our Constitution, which indicates that a continuance of these principles, with possible minor changes to meet altering conditions without alterations of our organic law, will, we believe, best serve organized medicine, encourage scientific investigation and best care for the sick and afflicted.

V. Annual Report of the *Committee on Publication.*

This report points out the value of the *Ohio State Medical Journal* as one of the most important activities of the Ohio State Medical Association. Besides its increasing importance from a scientific standpoint, *The Journal* brings to its readers every month valuable information of the activities of the component county societies; authentic and accurate information of especial interest to the members of the profession; through frequent and carefully prepared articles analyses of new problems and their ramifications as they affect medical practice are presented; digests of legal and court opinions of interest to physicians; summaries of new legislation and regulations, with timely report of the work of officers and committees of the State Association, and many news items keeping the physician informed on the activities of his colleagues, hospitals and health departments.

The report justly emphasizes the value of carefully preserving each issue and binding same at the end of each year, thus creating a volume which becomes a history of events and developments in the field of medicine in the State of Ohio.

The committee is to be congratulated upon its successful operation of this most valuable activity of our Association during the past year, with a deficit that is insignificant when considered in the light of its real value and importance to each and every member of its organization.

VI. Annual Report of the *Committee on Auditing and Appropriations.*

This report, which includes the report of the certified public accountant for the fiscal year, is evidence of close attention to the fiscal affairs of our Association, with a careful budgeting of our funds to secure the maximum return.

As in similar state professional and business organizations, the committee was in the past year confronted with unusual and perplexing financial problems, chiefly because of the lessened income from membership dues, combined with business adjustments made under the N. R. A., increase in commodity prices, reduction of the purchasing power of the dollar, and other economic factors, which greatly increased the operating cost of the organization.

The report emphasizes the necessity for continued economy and the maintenance of every precaution and safeguard to protect our resources and minimize our expenditures.

VII. Annual Report of the *Committee on Military and Veterans' Affairs.*

This report reviews the various changes in the policy and procedure of the federal government with regards to benefits for ex-service men including medical care and hospitalization during the past two years.

It deplores the fact that on March 28, 1934, because of pressure from all sides, Congress restored some of the benefits to ex-service men which had been removed by the "Economy Act" enacted by Congress early in 1933. The committee points out the dangers in the new hospitalization provision now on the statutes and emphasizes the need for judicious and concerted activity on the part of organized medicine in meeting the serious and difficult questions arising from medical and hospitalization phases of the veterans' program.

The report also stresses the value of cooperation of the medical profession in the matter of National Guard and Medical Reserve Corps enlistments.

VIII. Annual Report of the *Committee on Public Policy.*

This report summarizes some of the principal questions which the committee has been called upon to consider, presenting a clear-cut picture

of some of the important social and economic and governmental developments of this most critical period of the history of the medical profession.

Basic policies and principles have been re-emphasized and many of the dangers confronting the medical profession have been commented upon.

In its consideration of the future status of medicine, the committee emphasizes not only the right but also the obligation of the profession to voice its opinion and to take direct action regarding all social programs which directly or indirectly affect the health of the public and the practice of medicine. Believing that the future of medical practice is destined to be settled in the political arena, great stress has been placed upon the importance of every member of the profession using every influence at his command to have elected to public office men of sound judgment and experience, and quotes from their pronouncement of a previous date that "In this crisis it is patriotic to be politically-minded".

A very clear picture of the problem of medical care to indigents is presented. The committee is of the opinion that the relief program, including medical care, will be more than "temporary and emergency", and emphasizes the need for a full realization of the value of organized action. In this respect the report to some extent compromises some of the previously set forth basic principles in that it insists upon adequate compensation for medical service in any permanent plan for medical relief.

IX. Annual Report of the *Committee on Medical Economics.*

This report makes comment upon many of the factors which must be kept in mind by the profession in its efforts to work its way out of the maize of uncertainty, adversity and impending dangers brought about by the past few years.

Many new forms of medical service exemplifying the trends and tendencies brought about by the collapse of the boom period and the beginning of the present era of social and economic changes, are discussed.

The Principles of the Code of Ethics as they pertain to contract practice, hospital, industrial, group and clinic practice, are clearly set forth and leave no need for discussion.

A detailed account of the developments bearing on the administration of the Industrial Commission is presented, including the State Association committee's recommendations to the committee appointed by the Governor, with the resulting statutory changes.

The committee urges the need for consideration of economic aspects of the medical profession by every county society and academy of medicine, providing for discussion of serious economic problems at regular meetings.

The many problems coming under the realm of both public policy and medical economics are overlapping and closely interwoven and are of such great importance to each member of the profession, that we would at this time urge that these reports be not only read but thoroughly studied by every member of the profession; and believing that the respective committees would probably welcome viewpoints of interested delegates, we would at this time urge that they be offered for thorough discussion by this House of Delegates.

(Signed) OTTO J. SEIBERT, *Chairman,*
GUY E. NOBLE,
JOHN F. WRIGHT,
R. C. PAUL,
C. S. MCDOUGALL.

Dr. Seibert *moved* the adoption of the reports as a whole. The motion was seconded by Dr. Goodman. Those who discussed the motion and the reports of the committee were Dr. Greenebaum, Dr. Stone and Dr. Goodman.

The question being called for and put to a vote was *carried* and the committee report *adopted.*

Report of Committee on Resolutions

(The succeeding report of the Resolutions Committee on which official action was taken separately by sections, was signed by E. J. Emerick, chairman, D. C. Houser, C. W. Kirkland and Frank S. Gibson. J. C. Larkin the other member of the committee was not present at the time the report was signed).

TO THE HOUSE OF DELEGATES, OHIO STATE MEDICAL ASSOCIATION, AT THE 88TH ANNUAL MEETING, COLUMBUS, OHIO:

The Committee on Resolutions was impressed by the importance of the subject matter presented in the resolutions introduced at yesterday morning's session, attesting to the interest of the medical profession in the vital problems of the day.

The committee held several meetings, invited and heard authors of resolutions and other delegates and members interested in the subject matter of the proposals introduced.

In view of the matters and problems presented in the resolutions, the committee takes the liberty of presenting its discussion and recommendations in a consecutive rather than chronological order.

The Resolutions Committee submits for your consideration its comments and recommendations as follows:

RESOLUTION G

Introduced by D. W. Glover (Cuyahoga County). Having in mind the fundamental purpose of medical organization, the promotion of scientific practice and the promotion of public health, we consider it appropriate to present and recommend this resolution as our initial proposal.

The committee, therefore, recommends for approval Resolution G with slight amendments and changes in wording to read as follows:

WHEREAS, One of the fundamental purposes of medical organization is to promote the science and art of medicine and disseminate medical knowledge among the members of the medical profession; and

WHEREAS, The presentation of stimulating and instructive discussions at county medical society meetings is one of the most effective methods of promoting the continuous education of the physician; and

WHEREAS, Experience has shown that frequent participation by local physicians in scientific programs presented before their local medical society is an essential factor in keeping the membership of the society keyed to a high pitch of interest, enthusiasm and efficiency; be it

RESOLVED, That the House of Delegates of the

Ohio State Medical Association, in session October 4 and 5, 1934, Columbus, Ohio, urges each component county medical society or academy of medicine to give this important question its serious consideration and put forth during the ensuing year special efforts to enhance the value of its scientific activities.

We especially recommend that the officers and program committee of each county society or academy of medicine, if they have not already done so, acquaint themselves with and analyze carefully the "study outline" plan for county society programs. The merits and advantages of this and similar ideas for stimulating scientific activities were well summarized by Dr. C. L. Cummer on his President's Page published in the August, 1934, issue of *The Journal*, and under whose direction a number of suggested "study outlines" have been prepared and are being published in *The Journal*. The outlines prepared for *The Journal*, we believe, can easily be adapted to meet some of the program requirements of any county society or academy and it is our hope that the plan will be given an early trial by a large number of societies.

On *motion* by Dr. Emerick, seconded by Dr. Stone and *carried*, Resolution G was *adopted*.

Resolution J

In line with our interest in professional education, we approve heartily of the policy presented in Resolution J introduced by Henry B. Freiberg (Hamilton County), which not only compliments the three Class A medical schools in Ohio, but which urges closer cooperation between medical education and medical practice, which points out not only the importance of membership in medical organization of those physician instructors attached to the staffs of the medical schools, but which would encourage instructors in those schools to emphasize to prospective graduates the value and importance of medical organization as being helpful not only in a professional career but in the solution of economic and social problems with which those newly graduated are inevitably confronted.

The committee, therefore, recommends for adoption Resolution J as follows:

Whereas, Great responsibilities rest with the medical schools of the country in assisting the medical profession to meet the needs of and function effectively in an ever-changing social order, be it

Resolved, That the House of Delegates of the Ohio State Medical Association this 4th day of October, 1934:

Solicits the continued cooperation and assistance of Ohio's three Class A medical schools in efforts of organized medicine in Ohio to meet problems having an important bearing on the medical practice of the future;

Commends the medical schools of Western Reserve University, University of Cincinnati, and Ohio State University, for their activities over a long period of years, which have won for them high standing among the medical schools of the nation;

Urges them to give special consideration to the part the medical school should take in organized medicine's efforts to keep the supply of physicians reasonably near the number required to provide competent medical service; to institute such regulations or requirements that shall prevent overcrowding in the profession; correct, if possible, the uneven distribution of physicians; expand post-graduate opportunities for physicians in active practice; remedy unsatisfactory conditions resulting from over-crowding and lack of uniform standards in the specialties; keep the profession informed regarding the social aspects of medical practice and prepared to quickly adjust itself to changing social and economic conditions; stimulate in all physicians a devotion to the Principles of Medical Ethics and high scientific and moral standards; and, encourage membership and active interest in medical organization with special emphasis on the advantages, benefits and importance of concerted, organized activity;

Pledges the assistance of organized medicine in the preservation of the high standards attained by medical education in Ohio and the maintenance of adequate facilities so that medical students in Ohio may obtain the best possible training and instruction.

It is further RESOLVED that copies of the foregoing resolutions be sent to the deans of the three Class A medical schools in Ohio as an indication of the desire of medical organization to cooperate closely with medical education and as a matter of information on the expression contained in the resolutions and in the introductory report of the committee.

On *motion* by Dr. Emerick, seconded by Dr. Paul and *carried*, Resolution J was *adopted*.

Resolution C

Introduced by J. H. J. Upham (Franklin County). For many years medical organization has been directly and deeply interested in the principles and the administrative policies of workmen's compensation. Your Committee on Resolutions has been impressed by the effective activity of the Special Committee of our State Association on Workmen's Compensation, by the Committee on Medical Economics and the Council in their cooperation with the Governor's Investigating Committee on Workmen's Compensation and others interested in constructive changes and improvements in administrative procedure.

Some changes already recommended by our Association through appropriate committees have been inaugurated through the receptive attitude of the Commission and in conjunction with other groups interested in the same constructive purposes.

Your Committee on Resolutions, therefore, recommends for adoption Resolution C reading as follows:

Whereas, It is vital that the Ohio Workmen's Compensation System be maintained on a sound and efficient basis and

Whereas, The medical profession of Ohio is sincerely concerned in effective and equitable administration of the Workmen's Compensation Law and in the preservation and use of the compensation fund for purposes for which it is intended, and

Whereas, Constructive efforts now are being made to strengthen the structure of the Ohio

Workmen's Compensation System; improve its administration, and eliminate abuses of the fund;

THEREFORE BE IT RESOLVED, That organized medicine, in Ohio through the House of Delegates of the Ohio State Medical Association, assembled in Columbus, Ohio, October 4, 5 and 6, 1934, adopt the following:

1. Pledges its wholehearted and active support to the State Industrial Commission, the Governor's Investigating Committee on Workmen's Compensation, and other organizations and groups sincerely and directly concerned with the underlying principles of workmen's compensation and who are attempting to bring about constructive changes in the Ohio Workmen's Compensation Law and its administration.

2. Endorses and approves the recommendations and suggestions made by the Special Workmen's Compensation Committee of the Ohio State Medical Association to the State Industrial Commission and the Governor's Investigating Committee for improvements in the Workmen's Compensation System and urges all or any of those recommendations be put into effect as soon as possible.

3. Expresses appreciation for the faithful and efficient activities of the Special Workmen's Compensation Committee of the State Medical Association in representing so effectively the interests of the entire medical profession before the Industrial Commission and the Governor's Investigating Committee.

4. Condemns the actions of claimants, employers, physicians, or others, guilty of abuses and dishonest dealings with the State Industrial Commission and approves of efforts under way to safeguard the compensation fund from such abuses and to discipline guilty individuals.

5. Offers its active and organized assistance in efforts to secure for the Industrial Commission adequate annual appropriations from the General Assembly so that its administrative machinery may function effectively and be strengthened and improved.

On *motion* by Dr. Emerick, seconded by Dr. Cranch and *carried*, Resolution C was *adopted*.

RESOLUTION I

Interested as we are in proper information to the public for safeguards against disease and disability, we recommend for adoption Resolution I introduced by Theodore Miller (Cuyahoga County) as follows:

WHEREAS, Statistical data show that a considerable number of deaths of women during pregnancy, labor, or following childbirth in Ohio annually could be prevented if all prospective mothers would avail themselves of competent medical care during pregnancy; and

WHEREAS, An active campaign has been launched in the state by obstetricians, in cooperation with official public health departments, to promote greater public interest in the value and benefits of prompt and adequate prenatal care for expectant mothers by their family physicians;

BE IT RESOLVED, That this House of Delegates urges and recommends all members of the State Association to give their active cooperation and assistance to this movement by emphasizing to their individual patients the importance of early and competent medical care for pregnant women and by being prepared to render such service as a part of their daily practice.

On *motion* by Dr. Emerick, esconded by Dr. Coe and *carried*, Resolution I was *adopted*.

RESOLUTION B

In line with our civic duties as a profession intimately identified with the welfare and progress of humanity, we recognize our obligations to take a direct interest in public affairs for the improvement and greater efficiency of governmental agencies.

We, therefore, recommend for approval Resolution B, introduced by Carl R. Steinke (Summit County) in brief and simplified form as follows:

WHEREAS, There is in Ohio state-wide activity to bring about changes in local government machinery, to remedy duplication and overlapping and eliminate financial waste, in line with procedure approved by the electorate in adoption of a constitutional amendment in the Fall of 1933 for revision and economy in county government, and

WHEREAS, This question of governmental reorganization undoubtedly will come before the voters of many counties in the near future, be it

RESOLVED, That the House of Delegates, assembled in Columbus, October 4 and 5, 1934, recommend that physicians, as citizens and taxpayers, take a keen and active interest in proposals involving changes in the set-up and function of government, both state and local.

On *motion* by Dr. Emerick, seconded by Dr. Paryzek and *carried*, Resolution B was *adopted*.

RESOLUTION E

Introduced by Sidney McCurdy (Mahoning County), requests approval and endorsement of a legislative proposal formulated by the Ohio Hospital Association for a reorganization and centralization of all health problems, to provide medical and surgical care and hospitalization for indigent persons under one head—the local "health commissioner". This resolution, in requesting support for the bill as drafted by the Hospital Association, contemplates approval of proposals to repeal, amend and substitute several sections of the General Code of Ohio and to establish an entire new and different system of poor relief.

Your Committee on Resolutions agrees with much of the intention and sentiment expressed in this resolution, i.e., that Ohio poor laws are antiquated, unwieldy and uncoordinated. Your committee further agrees with the spirit of the resolution, which emphasizes the importance of preserving to patients the free choice of their own physician, and we are further in sympathy with the idea that those who are on public relief deserve adequate medical care as well as other necessities as a part of governmental obligation.

Your Resolutions Committee feels that Resolution E is premature; in view of the fact that under the constitutional amendment adopted last year (referred to in Resolution B), a Governor's Commission on County Government as well as other interested groups are preparing to introduce legislation in the next session of the General As-

sembly to radically amend not only the set-up and function of county government, but probably to establish an entire new system of relief to the needy, including medical care and also including proposals affecting public health administration, perhaps in conflict with the intention expressed in Resolution E to centralize health and medical relief in the local health department, and in view of the complicated nature of this situation and the prospect for many and far-reaching legislative proposals on this general subject, supplemented by the fact that a series of conferences in the near future has already been arranged on this matter between the Policy Committee of the Ohio State Medical Association, the Legislative Committee of the Ohio Hospital Association and officials of the State Department of Health.

We, therefore, recommend that the foregoing report be approved and that Resolution E not be adopted.

Dr. Emerick *moved* that the foregoing recommendations of the committee, rather than the resolution itself, be adopted. The motion was seconded and discussed by Dr. McCurdy, and on being put to a vote was *carried*. Thus the foregoing report was *approved*.

Resolution D

Introduced by Drew L. Davies (Franklin County). We believe this resolution meets a few, at least, of the problems raised in Resolution E, and your Resolutions Committee recommends its adoption as slightly edited to read as follows:

WHEREAS, In many counties of the state, physicians are being paid nothing or inadequate fees on a pro rata basis for services rendered by them to indigents and the temporarily unemployed, and

WHEREAS, In most of the counties where this situation prevails, the local relief director is primarily to blame because of his failure to budget each month the maximum sum available for medical service to those on relief under Rules and Regulations No. 7, FERA, or because he has used such funds, when allotted by the State Relief Commission, for other relief work, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association protest this shortsighted attitude on the part of some county relief directors, and

BE IT FURTHER RESOLVED, We recommend to the county medical societies or academies of medicine in counties where this condition exists, that they, if they have not already done so, arrange for conferences with the officials of their local relief administration; emphasize to them the desirability and necessity of more thorough consideration of local medical needs under the relief plan; request that funds within the maximum allowance of the State Relief Commission be budgeted and used for medical services wherever required, and ask for the appointment of a local medical advisory committee from among the membership of the society or academy to assist the relief administration with medical questions and serve as a contact medium between the relief director and the local medical profession.

On *motion* by Dr. Emerick, seconded by Dr. Beer and *carried*, Resolution D was *adopted*.

Resolution F

Bearing directly on some of the fundamental economic problems already touched upon in other phases by the preceding comment is Resolution F introduced by Otto J. Seibert (Hamilton County), which your Resolutions Committee recommends for adoption as edited, simplified and shortened to read as follows:

WHEREAS, Powerful forces and agencies are attempting to bring about in this country radical changes in medical service and the relations between physician and patient, and

WHEREAS, It is of vital importance that the policy of organized medicine toward such experiments now under way, or advocated, be clearly and definitely understood by both the public and the members of the medical profession, and

WHEREAS, It is essential that the medical profession stand united on policies and principles relating to scientific medicine, public health and medical practice,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association, representing the overwhelming majority of physicians of Ohio, reaffirms the established policy of organized medicine toward changes in the nature of medical practice as follows:

We favor and actively support changes in the nature of medical practice which are basically sound, practical and necessary, in the interests of the public, and in accord with sound public policy.

We favor and encourage improvements in providing medical service to the public which are properly controlled and based on sound social, economic and medical principles.

We condemn as detrimental to public interest and scientific medicine and vigorously oppose experiments, schemes, programs or proposals, involving changes in the present system of medical service and medical practice which violate any of the principles unanimously adopted by the House of Delegates of the American Medical Association on June 12, 1934, at Cleveland, Ohio, and published as a part of the official minutes in the June 30, 1934, issue of *The Journal of the American Medical Association*, pages 2199 and 2200.

On *motion* by Dr. Emerick, seconded by Dr. Paryzek and *carried*, Resolution F was *adopted*.

Resolution K

This resolution, introduced by George L. Sackett (Tuscarawas County), contains three sections numbered consecutively 1, 2 and 3, and your committee submits the following report on this resolution by sections.

K-1

This resolution would call for the appointment by the House of Delegates of a committee to investigate and make a critical review of the relations of the Ohio State Medical Association to all branches of state welfare and indigent relief in order to obtain more effective supervision of the medical phases of these departments by the medical profession; further, that report of such

activities be made to the Council. And finally, that the said committee, after making investigation and report to the Council, be authorized to act as a contact committee with the medical profession in Ohio and to deal and cooperate with state departments on welfare and current problems of relief in this state.

Your Committee on Resolutions has given the proponents of this resolution the hearing requested, and it has also called in officers of this Association and members of the Policy Committee.

We find that the officers, Council and Policy Committee have exerted every effort to work out satisfactory solutions of these complex problems, and that the Policy Committee is thoroughly conversant with all phases. These questions have been fully discussed in the issues of our official organ, the *Ohio State Medical Journal*, and the membership has been kept fully informed by this means.

For these reasons, your Committee on Resolutions feels that there is no necessity for the appointment of a special committee to re-cover this ground, especially since it is the constitutional function and duty of the Policy Committee, reporting to the Council.

On *motion* by Dr. Emerick, seconded by Dr. Shanley and *carried*, the foregoing recommendations and report of the Resolutions Committee were *adopted*.

K-2

This resolution would instruct the Committee on Policy to register a complaint against the editorial expression in the *Ohio State Medical Journal* of partisan opinion concerning social-political problems not directly pertaining to the practice or science of medicine.

This resolution does not cite any specific instances of the expression of such partisan opinion.

In a conference with the author and proponents of this resolution, they failed to submit examples of "partisan opinions", and those articles or declarations to which they made reference were those which had been officially adopted by the Council following consideration by the Policy Committee, and which dealt with social theories or social philosophy rather than with partisan opinions. The Council, the Policy Committee and the Publication Committee have faithfully followed as a guide principles repeatedly enunciated by the House of Delegates, and under such official direction or with such official approval, editorial declarations, expressions and articles of information have been published in *The Journal*.

Therefore, this committee recommends that the resolution be not adopted, and also recommends that the management of *The Journal* be commended for the news and editorial articles which have been helpful in informing the membership regarding social, economic and legislative matters of vital importance to the medical profession.

On *motion* by Dr. Emerick, seconded by Dr. Cranch and *carried*, the foregoing recommendations and report of the Resolutions Committee were *adopted*.

K-3

The preamble to this resolution states that the income of physicians has diminished; that the operating expenses of this Association exceeded the income from membership dues; that the salaries of the executive secretary and his assistant and their expenses totaled $11,325.00, a sum approximately one-half of the annual income from dues. The proposed resolution would direct the Committee on Auditing and Appropriations to revise its budget downward.

In regard to excess of expenditures over receipts from annual dues, the actual facts are as follows: As shown by the auditor's report for the calendar and fiscal year of 1933, the total annual expenses, including Annual Meeting expense, were $25,936.39. The revenue from dues and from the receipts of the Annual Meeting (which should be included since corresponding expenses are included in total expenses), totalled $27,291.00, leaving a net operating balance of $1,354.61, which does not include income from investments. Therefore, the statement embodied in the resolution is substantially incorrect.

Your Committee on Resolutions feels that the Council, to which is properly delegated by the Constitution the authority on matters of salaries, administrative, executive and routine expenses, should and does have intimate and accurate knowledge of the value and importance of staff duties, functions and detailed administrative expense.

The Committee on Resolutions has interviewed officers of the Association and has ascertained from them the character of services rendered by our staff, of their loyalty, faithfulness and devotion, and it is the feeling of the committee that the ratio of expenditures on this service is none too high in what is essentially a service organization.

Therefore, your Committee on Resolutions recommends that this resolution be not adopted.

On *motion* by Dr. Emerick, seconded by Dr. Shanley and *carried*, the foregoing recommendations and report of the committee were *adopted*.

RESOLUTION H

This resolution, introduced by John P. DeWitt (Stark County), recognizes the unprecedented problems which have confronted the medical profession as well as all other groups in recent months, and properly commends the efforts and activities of officers and committees who have labored unselfishly on our behalf.

In these times of uncertainty, dissatisfaction and inevitable criticisms, we are pleased to recommend this resolution reading as follows:

WHEREAS, Heavy demands have been made upon the officers, Councils, committees and headquarters staff of the State Association during the past twelve months in representing and protecting the interests of the medical profession in public matters, because of the material increase in the number and importance of social, economic, governmental, and legislative problems affecting scientific medicine, public health and medical practice, and the necessity for medical organization to assume greater responsibilities in seeing that the consistent, sound, conservative and concerted medical viewpoint on such questions is expressed and emphasized, be it

RESOLVED, By the House of Delegates of the Ohio State Medical Association in 88th annual meeting at Columbus, October 4, 5 and 6, 1934, that appreciation and approval be expressed to the officers, Councilors and committees of this association for their faithful and meritorious activities during the past year; to our executive staff for effective and devoted services in the interests of the profession and in promotion of the aims and purposes of organized medicine, and be it further

RESOLVED, That appreciation be expressed to those officers, committeemen and other members of the component county medical societies and academies of medicine who have cooperated to the fullest extent in the activities of our State Association. Through their help and assistance many constructive things have been accomplished for the good of the profession as a whole. Their continued support and active interest are essential to the concerted, organized efforts which we must put forth during the ensuing year.

On *motion* by Dr. Emerick, seconded by Dr. Slosser and *carried*, Resolution H was *adopted*.

RESOLUTION A

In the expression contained in his presidential address last evening, we agree with Dr. Cummer that in these rapidly changing and strenuous times continuity of experienced service is important and valuable in our headquarters staff, and on an anniversary occasion we consider it appropriate to recommend adoption of Resolution A, introduced by H. C. King (Cuyahoga County), reading as follows:

WHEREAS, In February of this year, Don K. Martin, Esq., completed fifteen years of service to this Association; and,

WHEREAS, He has given to the Association his best efforts and has served it with unusual faithfulness and ability, and,

WHEREAS, He has shown in the fulfillment of his duties singular devotion, excellent judgment, and deep appreciation of the ideals and traditions of the medical profession; and,

WHEREAS, It is appropriate that this fifteenth anniversary be commemorated by some recognition of his service;

THEREFORE, BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association in annual session assembled in the city of Columbus that the thanks of the Association be extended to him for his sincere interest, his loyalty, and his fidelity to its interests and those of its members.

On *motion* by Dr. Emerick, seconded by Dr. Cranch and *carried*, Resolution A was *adopted*.

Meeting Place for 1935

Parke G. Smith presented to the House of Delegates an invitation from Cincinnati for the Annual Meeting in 1935 at a time to be selected by the Council, and *moved* that Cincinnati be selected as the meeting place. The motion was seconded by Dr. Seiler and *carried*.

President Cummer asked for expression and action by the House of Delegates on whether the meeting should be held in the Spring or in the Fall.

Dr. Caldwell *moved* that the Council be instructed to fix a suitable and convenient date in the Fall of 1935 for the next Annual Meeting in Cincinnati. This motion was seconded by Dr. Paryzek. In discussion, the motion was supported by Dr. Dickenson, Dr. Paryzek, Dr. Caldwell and Dr. Davidson. In discussion the motion was opposed by Dr. Lukens, Dr. Slosser, Dr. Hein and Dr. Hogue. The motion was otherwise discussed by Dr. Goodman and Dr. Boylan.

On being put to a vote, the motion by Dr. Caldwell was *adopted* by a vote of 27 to 14, thus instructing the Council to set a suitable date in the Fall of 1935 for the next Annual Meeting.

Appreciation Expressed

Upon *motion* by Dr. Davidson, seconded by Dr. Cranch and *carried*, the House of Delegates, on behalf of all the members in attendance at the Annual Meeting, expressed appreciation to the Columbus Academy of Medicine, to its local committees whose management of numerous details contributed to the success of the meeting, to the Columbus Chamber of Commerce for its assistance in connection with registration and information, to the Neil House for its facilities and service, and to all others whose hospitality was extended to those in attendance.

Dr. Boylan expressed approval and commendation to the Council Program Committee, the Section officers, the essayists, discussants and the scientific exhibitors for a splendid program and scientific demonstration. His remarks were concurred in by other delegates.

Introduction of New Councilors

At this point, President Cummer introduced the two new Councilors, who had been elected earlier in this session, and at this point installed them in their positions: A. A. Jenkins, Cleveland, Fifth District; C. W. Kirkland, Bellaire, Seventh District.

Installation of New President

Before retiring as president and as his last official act, Dr. Cummer expressed appreciation to the House of Delegates for its faithful function at this Annual Meeting, to the other officers, Council, committees, the officers of the component

societies and the membership for support and cooperation throughout his administration.

Dr. Cummer introduced Dr. Caldwell, the president-elect, and installed him as the president for the ensuing year by presenting to him the official gavel. Dr. Caldwell expressed his desire to serve with efficiency and fairness as exemplified by his predecessors, and solicited the same character of support and cooperation.

Appointment and Confirmation of Standing Committees

Under the next order of business of the House of Delegates, and as his first official act, Dr. Caldwell, in conformity to Chapter IX, Section 1, of the By-Laws, announced the appointment of one member each on the standing committees for a term of three years as follows:

Public Policy:

J. H. J. Upham, Columbus.

Publication:

Andrews Rogers, Columbus.

Medical Defense:

J. E. Tuckerman, Cleveland.

Medical Education and Hospitals:

Ben R. McClellan, Xenia.

Medical Economics:

L. L. Bigelow, Columbus.

On *motion* by Dr. Cummer, seconded by Dr. Goodman and *carried*, the House of Delegates concurred in the foregoing appointments.

President Caldwell then announced the complete personnel of the standing committees under the Constitution, including the hold-over members, the year in which the terms of members expire, and the chairman designation, as follows:

Committee on Public Policy:

J. H. J. Upham, Chairman, (1937) Columbus; C. W. Stone (1935), Cleveland; J. B. Alcorn (1936), Columbus; John A. Caldwell (Ex-Officio), Cincinnati; R. R. Hendershott (Ex-Officio), Tiffin.

Committee on Publication:

Andrews Rogers, chairman, (1937), Columbus; Gilbert Micklethwaite (1935), Portsmouth; A. B. Denison (1936), Cleveland.

Committee on Medical Defense:

J. E. Tuckerman, chairman, (1937), Cleveland; F. P. Anzinger (1935), Springfield; W. H. Snyder (1936), Toledo.

Committee on Medical Education and Hospitals:

Ben R. McClellan, chairman, (1937), Xenia; R. H. Birge (1935), Cleveland; John F. Wright (1936), Toledo.

Committee on Medical Economics:

L. L. Bigelow, chairman, (1937), Columbus; E. O. Smith (1935), Cincinnati; J. Craig Bowman (1936), Upper Sandusky.

Further business being called for and there being none presented, the House of Delegates adjourned to meet in 1935 in Cincinnati on dates to be selected by the Council.

ATTEST: DON K. MARTIN,
Executive Secretary.

House of Delegates Roll Call

County	Delegate	First Session	Second Session
Adams	Ray Vaugben	present	present
Allen	Ezra Burnett	———	———
Ashland	George Riebel	present	present
Ashtabula	R. B. Wynkoop	present	present
Athens	Chas. S. McDougall	present	present
Auglaize	Guy E. Noble	present	present
Belmont	C. W. Kirkland	present	present
Brown	———	———	———
Butler	W. E. Griffith	———	———
Champaign	D. C. Houser	present	present
Clark	D. W. Hogue	present	present
Clermont	Allan B. Rapp	———	present
Clinton	Elizabeth Shrieves	present	present
Columbiana	P. H. Beaver	———	———
Coshocton	Samuel Cohen	———	———
Crawford	D. G. Arnold	present	present
Cuyahoga	C. W. Stone	present	present
"	D. M. Glover	present	present
"	A. A. Jenkins	present	present
"	H. C. King	present	present
"	John Dickenson	present	present
"	F. S. Gibson	present	present
"	Theodore Miller	———	present
"	J. E. Tuckerman	present	present
"	A. G. Cranch	———	present
"	Geo. F. Sykes	present	present
"	Milton B. Cohen	present	———
"	C. G. LaRocco	present	———
Darke	C. I. Stephen	present	present
Defiance	D. J. Slosser	present	present
Delaware	M. S. Cherington	———	———
Erie	F. M. Houghtaling	———	———
Fairfield	R. H. Smith	present	present
Fayette	Lucy W. Pine	present	———
Franklin	John Thomas	present	present
"	Drew Davies	present	present
"	E. J. Emerick	present	present
"	I. B. Harris	———	present
"	J. H. J. Upham	present	present
Fulton	R. W. Reynolds	———	———
Gallia	Mary L. Austin	present	present
Geauga	H. E. Shafer	———	———
Greene	L. L. Taylor	present	present
Guernsey	Geo. F. Swan	present	present
Hamilton	J. Victor Greenebaum	present	present
"	Otto J. Seibert	present	present
"	Ralph W. Good	———	present
"	Henry B. Freiberg	present	present
"	Chas. E. Kiely	present	present
"	L. H. Schriver	present	present
Hancock	J. M. Firmin	present	present
Hardin	Don R. Printz	present	present
Harrison	W. C. Wallace	———	———
Henry	Thomas Quinn	———	———
Highland	J. C. Larkin	———	———
Hocking	H. M. Boocks	present	———
Holmes	A. T. Cole	———	———
Huron	———	———	———
Jackson	A. G. Ray	present	present
Jefferson	S. A. Harris	present	present
Knox	F. C. Anderson	present	present
Lake	V. N. Marsh	present	present
Lawrence	Cosper Burton	———	———
Licking	Emmett A. Moore	present	present
Logan	C. K. Startzman	present	present
Lorain	S. V. Burley	present	present
Lucas	Charles Lukens	present	present
"	C. W. Waggoner	———	present
"	John F. Wright	present	present
Madison	R. W. E. Irwin	———	———
Mahoning	L. G. Coe	present	present
"	Sidney McCurdy	present	present
Marion	E. L. Brady	present	present

County	Delegate	First Session	Second Session
Medina	E. L. Crum	———	present
Meigs	Raymond E. Boice	———	———
Mercer	Paul E. Rex	present	present
Miami	G. A. Woodhouse	———	present
Monroe	———	———	———
Montgomery	A. W. Carley	present	present
"	A. O. Peters	present	present
"	H. V. Dutrow	present	present
Morgan	Galen Rex	———	present
Morrow	F. M. Hartsook	———	present
Muskingum	M. A. Loebell	———	present
Noble	———	———	———
Ottawa	H. J. Pool	———	———
Paulding	L. R. Fast	———	———
Perry	C. B. McDougal	———	present
Pickaway	H. D. Jackson	present	present
Pike	Robert T. Leever	———	———
Portage	E. H. Knowlton	———	present
Preble	J. I. Nisbet	———	present
Putnam	B. E. Waterson	———	present
Richland	W. E. Wygant	———	———
Ross	A. E. Merkle	———	———
Sandusky	D. W. Philo	———	———
Scioto	G. R. Micklethwaite	present	present
Seneca	R. R. Hendershott	———	present
Shelby	V. W. LeMaster	———	———
Stark	J. P. DeWitt	present	present
"	R. L. Rutledge	present	present
Summit	J. G. Blower	———	present
"	F. C. Potter	present	present
"	C. R. Steinke	present	present
Trumbull	R. D. Herlinger	present	present
Tuscarawas	Geo. L. Sackett	present	present
Union	J. D. Boylan	present	present
Van Wert	Roland H. Good	present	present
Vinton	A. A. Boal	present	———
Warren	N. A. Hamilton	present	———
Washington	R. W. Riggs	present	present
Wayne	R. C. Paul	present	present
Williams	H. W. Wertz	———	———
Wood	H. J. Powell	present	present
Wyandot	J. Craig Bowman	present	present
OFFICERS			
President	C. L. Cummer	present	present
President-Elect	John A. Caldwell	present	present
Ex-President	H. M. Platter	present	present
Treasurer	James A. Beer	present	present
COUNCILORS			
First District	Parke G. Smith	present	present
Second District	E. M. Huston	present	present
Third District	O. P. Klotz	present	present
Fourth District	B. J. Hein	present	present
Fifth District	H. V. Paryzek	present	present
Sixth District	H. S. Davidson	present	present
Seventh District	E. B. Shanley	present	present
Eighth District	E. R. Brush	present	present
Ninth District	I. P. Seiler	present	present
Tenth District	S. J. Goodman	present	present
	Total	85	96

COUNCIL MEETING MINUTES DURING 88TH ANNUAL MEETING, OCTOBER 4, 5 AND 6, 1934

MINUTES

The Council of the Ohio State Medical Association met at dinner in the Red Room, mezzanine floor, Neil House, Wednesday evening, October 3, 1934, on the evening preceding the opening of the 88th Annual Meeting of the State Association.

The officers, Councilors, committee chairmen and others present were: President, Dr. Cummer; President-Elect, Dr. Caldwell; Ex-President, Dr. Platter; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Paryzek, Davidson, Shanley, Brush, Seiler and Goodman; Dr. Stone, chairman, and Dr. Upham, member, Policy Committee; Dr. Rogers, chairman, Publication Committee; Dr. Tuckerman, chairman, Medical Defense Committee; Dr. Bowman, chairman, Medical Economics Committee; Dr. McClellan, chairman, Committee on Medical Education and Hospitals; Dr. Dodd, president, Columbus Academy of Medicine; Dr. Bigelow, general chairman, local committees on arrangements; Dr. Southard, State Director of Health; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

Following the dinner, the Council convened in business session at 8:00 P. M.

The minutes of the Council meeting held on July 8, 1934 (pages 512 to 515, inclusive, of the August, 1934, issue of *The Journal*), were read, and on *motion* by Dr. Paryzek, seconded by Dr. Platter and *carried* were *approved.*

ANNUAL MEETING ANNOUNCEMENTS

Dr. Bigelow, general chairman of the local committees on arrangements, and Dr. Dodd, the president of the Columbus Academy of Medicine, were called upon by the President and made brief announcements concerning the plans and activities of the local committees for the entertainment of the convention. Attention was called to the schedule of meeting places and other details as contained in the official pamphlet program for the meeting.

WORKMEN'S COMPENSATION DEVELOPMENTS

Dr. Hein, the chairman of the Special Committee on Workmen's Compensation, reported on the activities of his committee and developments in connection with administrative improvement at the State Industrial Commission since the last Council meeting. He analyzed the official communication from his committee to the Governor's committee under date of July 25, supplementing previous communications and recommendations. He also called attention to the article in the August *Journal*, page 530, and the article in the September *Journal*, page 602, relating to workmen's compensation developments as well as prospective legislation pertaining to workmen's compensation and the Industrial Commission.

Dr. Hein also announced the recent personnel added to the staff of the Medical Department of the Commission and plans for speeding up the handling of cases including payment of fees to physicians rendering services in workmen's compensation cases.

LEGISLATION AND POLICY

Dr. Stone, chairman of the Policy Committee, reported at length on a meeting of his committee

held on the afternoon of this day, including a summary on a variety of proposals expected to be introduced in the Legislature under the constitutional amendment of last year, permitting revision and consolidation in county government. He reported on the inquiry being made and the prospective report by the Governor's Commission on Reorganization of County Government expected to permit a variety of county administrative set-ups depending on population and character of respective county units. He also reported on prospective proposals to change the present statutes on poor relief, including medical care to the indigents, in connection with the reorganization of county government as a part of a revision of the present emergency relief statutes, in connection with health administration and involving a proposal formulated by the Ohio Hospital Association on which a conference is arranged for the near future between the Policy Committee of the State Medical Association, the Legislative Committee of the Ohio Hospital Association and officials of the State Department of Health.

A report was also made by Dr. Stone on prospective legislation from various sources to change the State Department of Health statutes and the Ohio Health Code, including a prospective proposal to establish standards of requirements for local health departments as a prerequisite to their sharing in the state health subsidies, the possibility of a revision in the manner of selecting local boards of health in general health districts, and how such proposals might be influenced by revision and consolidation of functions in county government.

Among other matters reported on by Dr. Stone was an analysis of the effect of the pending constitutional amendment to limit the gasoline tax to 3¢ and confine its use to the construction and maintenance of highways; and also the proposed amendment to prevent diversion of funds for purposes other than those originally levied, in connection with the present state law reimbursing hospitals for the care of indigents injured in automobile accidents through the Maintenance and Repair Fund of the State Highway Department.

Prospective legislation directly affecting allied professions was also discussed by Dr. Stone; and he and Dr. Hein reported on prospective workmen's compensation legislation, especially provisions to modify the occupational disease sections of the Workmen's Compensation Act.

Prospective legislation on probate procedure, juvenile court statutes, expert testimony, welfare, coroner system, medical examiners under prosecuting attorney, sterilization, taxation and cults was also reported on by Dr. Stone.

Members of the Policy Committee also reported briefly on developments and the present status of medical care under the FERA, and reference was made to articles published in *The Journal* since the last Council meeting, as follows: August issue, pages 528 and 529; September issue, pages 599 to 601, inclusive; October issue, page 650.

JUDICIAL AND CONSTITUTIONAL QUESTIONS

Dr. Platter, chairman of the Special Judicial Committee of the Council, reported on correspondence from the Academy of Medicine of Lima and Allen County relative to constitutional provisions in disciplinary action, suspension and expulsion.

On *motion* by Dr. Platter, seconded by Dr. Huston and *carried*, the secretary was instructed to acknowledge the communication under date of September 29, 1934, from a committee of the Academy of Medicine of Lima and Allen County, and the acceptance by the Council of the constitutional revisions certified in that communication.

MISCELLANEOUS

Attention was called to the program for the 44th Annual Session of the Ohio Welfare Conference to be held in Cincinnati, October 10 to 13, with special reference to the subjects under consideration in the program of that conference pertaining to health-welfare. In accordance with custom, President Cummer suggested that an observer be designated to attend the conference, and submit a report to the Council. President Cummer placed this matter in the hands of the local Councilor, Dr. Smith.

Dr. Cummer reported on correspondence relative to the Ohio State Executive Committee on State Survey of Infantile Paralysis. Dr. Southard and Dr. Upham also briefly reported on developments by that committee.

Dr. Cummer referred to the activities of the Committee of the Ohio Bar Association on Judicial Administration and Legal Reform relative to a state commission to draft proposed legislation regarding marriage, divorce and separation.

The chairmen of the standing committees of the State Association present at the meeting were introduced and invited to submit comments.

A report on membership statistics showed 5,307 members to date for 1934, compared with 5,048 on the same date last year and with the total for last year of 5,187.

On *motion* by Dr. Huston, seconded by Dr. Seiler and *carried*, the Council expressed appreciation to the President for his leadership during the year of his administration now closing, and also extended thanks to him for photographs of the Council which he presented at this meeting.

Dr. Cummer thanked the Councilors and committees for their support and cooperation.

There being no further business brought before the meeting, the Council adjourned to meet with

the House of Delegates on the following morning, October 4, at 9:00 A. M.

WITH THE HOUSE OF DELEGATES

The Council of the Ohio State Medical Association met with and as a part of the House of Delegates at the Neil House, Columbus, on Thursday, October 4, 1934, at 9:00 A. M., and also with the second and last session of the House of Delegates during the Annual Meeting at 3:30 P. M. on Friday, October 5, and participated officially in both sessions. Minutes of the Council meetings with the House of Delegates are included as part of the proceedings of the latter in this issue of *The Journal.*

FINAL COUNCIL SESSION

The final session of the Council during the 88th Annual Meeting was held at 5:15 P. M. following the adjournment of the House of Delegates on October 5.

Dr. Caldwell, newly-installed President, called the meeting to order and asked for nominations for secretary of Council.

Dr. Seiler nominated Dr. Goodman. There being no other nominations, Dr. Goodman was elected by acclamation.

The Council adjourned to meet at the call of the President.

Signed: JAMES A. BEER, M.D.,
Secretary of Council.

THE ANNUAL MEETING WAS A SUCCESS FROM ALL ANGLES—SCIENTIFIC, ATTENDANCE, PROGRAM, ENTERTAINMENT AND ORGANIZATION

In all respects, the Eighty-Eighth Annual Meeting of the Ohio State Medical Association, held Thursday, Friday and Saturday, October 4, 5 and 6, at the Neil House, Columbus, was a fitting tribute not only to the memory of that small group of pioneer Ohio physicians who met 88 years ago on the very site of this year's meeting to lay the foundation of medical organization in Ohio, but to the character and initiative of the present medical profession of the state.

A comparison of the historical data on that meeting in the old Neil House in 1846 and subsequent early gatherings of the Ohio State Medical Association with the proceedings and program of the 1934 assembly, indicates the remarkable progress which has taken place in the field of medicine in Ohio during the past eight and one-half decades through the leadership and activity of medical organization.

Advances of tremendous importance and far-reaching effect have been made in the science and art of medicine during the past 88 years as exemplified by the program of addresses and discussions on the cause and treatment of scores of diseases and conditions, many of which were unknown to the Association's founders.

The fact that it was possible to hold a meeting of such size and importance, with its great opportunities for self-improvement and exchange of ideas, attests to the soundness of the logic and action of those physicians of 1846, who realized that only through consolidation of enterprise and cooperative activity could the medical profession advance, maintain its independence, and solve its problems, and shows the effective manner in which organized action has been maintained and improved through the years by succeeding generations of physicians.

There is much evidence in the record of this year's meeting that the character of the medical profession of Ohio is the same fundamentally as it was in the pioneer days when the foundations of present-day medical practice and present-day medical organization were laid by members of the profession, notable and respected for their fortitude and perseverance in the face of adversity; unselfish devotion to the public's interests and to duty; faith in the traditional principles and ethics of medicine; enthusiasm for and active support of projects for advancing the science and art of medicine, increasing the safeguards to public health, and preparing the physician for more effective service; and willingness to sacrifice time and effort in promoting organized activity for the good of the profession as a whole and the public at large.

The attendance at the Columbus meeting was ample proof that today's physicians, like those of the past, are ready to make real sacrifices to prepare themselves for improved service to the public. Moreover, it clearly indicated that members of the profession are unwilling to let adversity and uncertainty, resulting from the most critical period in its history, dampen their desire for scientific improvement and the promotion of the purposes of medical organization. Throughout the entire meeting there was evidenced a spirit of confidence in the ideals and purposes of scientific medicine and in the motives of medical organization; determination to meet new responsibilities and obligations; and certainty in the ability of the profession to solve problems about which it

is best informed and best able to adjust in a way that will be constructive and beneficial.

Although the registration was not as large as it undoubtedly would have been in normal times and had the annual session of the American Medical Association not been held in Ohio earlier in the year, it surpassed expectations. In fact the total attendance (including guests) was above the average for the past 16 years and only slightly below the average at meetings held in Columbus during that period. When compared to the attendance figures reported for meetings of similar professional and business groups in the state and nation during recent months, the registration was not only satisfactory but remarkable.

* * * *

From an educational standpoint, this year's meeting established a high mark and one that those given the responsibility of arranging future annual meeting programs will find difficult to surpass.

The scientific program, consisting of six general sessions—exclusive of the two sessions of the House of Delegates and the annual dinner—and two sessions of each of the six Scientific Sections, was a testimonial to the tireless services and rare judgment of the Council Program Committee, consisting of Dr. H. V. Paryzek, chairman, Dr. John A. Caldwell and Dr. H. M. Platter.

Sharing with them the credit for the high caliber of the program are the officers of the various sections who cooperated to the fullest extent with the Program Committee and the essayists and discussants who, in the last analysis, make the program possible.

Under the energetic and faithful chairmanship of Dr. Paryzek, the Program Committee provided the membership with discussions and demonstrations of unusual interest and importance and assembled an impressive array of talent to present the subjects selected.

Because of the splendid work and cooperation of the following section officers, the Program Committee was able to formulate unusually fine programs for each of the Scientific Sections:

Medical, Dr. Cecil Striker, Cincinnati, chairman; Dr. Harry W. Gauchat, Canton, secretary; surgical, Dr. Norris W. Gillette, Toledo, chairman; Dr. Verne A. Dodd, Columbus, secretary; obstetrics and pediatrics, Dr. John Toomey, Cleveland, chairman; Dr. J. K. Hoerner, Dayton, secretary; eye, ear, nose and throat, Dr. Ivor G. Clark, Columbus, chairman; Dr. Orville J. Walker, Youngstown, secretary; nervous and mental diseases, Dr. Henry C. Schumacher, Cleveland, chairman; Dr. C. C. Kirk, Orient, secretary; public health and preventive medicine, Dr. R. H. Markwith, Akron, chairman; Dr. P. A. Davis, Akron, secretary.

The program covered practically every important phase of scientific medicine, appealing to both general practitioner and specialist. It offered a rare opportunity to the membership to add to its store of knowledge and better prepare itself to meet ever-increasing medical problems.

In compliance with the sentiment expressed by many members during recent years, the Committee arranged for a greater number of general sessions and secured for these, speakers particularly qualified to discuss some of the newest and most complex questions now confronting scientific medicine.

The State Association was especially fortunate and honored in having as guest speakers: Dr. R. T. Woodyatt, Chicago, who discussed "Diabetes Mellitus"; Dr. Russell L. Cecil, New York, who delivered an address on "Chronic Arthritis"; Dr. A. C. Furstenberg, Ann Arbor, Michigan, and Dr. Mark J. Schoenberg, New York, who addressed the Eye, Ear, Nose and Throat Section, and Dr. Charles P. Emerson, Indianapolis, who presented a scholarly address on "Psychoneurotic Reactions" at the Thursday evening session following the annual addresses of the incoming president, Dr. John A. Caldwell, Cincinnati, and the retiring president, Dr. C. L. Cummer, Cleveland. The addresses of the incoming and retiring presidents will be found elsewhere in this issue of *The Journal.* Dr. Emerson's address was well-received by the large audience present to honor Dr. Cummer and Dr. Caldwell. In it he supported the theory that psychoneurotic reactions are many times the basic causes of physical conditions attributed to other causes and that they are frequently peculiar to certain races and nationalities, resulting in certain diseases and conditions being more prevalent among those peoples than the people of other countries.

Large and enthusiastic audiences attended all the general sessions and there was much favorable comment on the presentations made at them.

As in past years, the programs presented at the sessions of the Scientific Sections were varied and well-balanced. The subjects were handled in an excellent manner by the essayists and discussants.

The first sessions of the Scientific Sections on Thursday afternoon were well-attended. However, the attendance at the section meetings on Saturday morning was disappointing, despite the fact that many papers of interest and importance were presented.

It was the general opinion that the small attendance on Saturday morning at the various section sessions was due to the fact that many physicians were unable to remain away from their offices through Saturday. The opinion was expressed by many that in the future the section meetings should be held on consecutive days and that an effort should be made to avoid having the meeting extend through Saturday.

Viewed as a whole, the program was a real

tribute to all who worked long and faithfully in arranging and presenting it, and provided those fortunate enough to have attended the meeting with instruction of inestimable value.

* * * *

Functioning efficiently and courageously, the House of Delegates under the able chairmanship of Dr. Cummer, transacted an unprecedented amount of business, as the official minutes of both its sessions, published elsewhere in this issue of *The Journal*, indicate.

Both sessions of the House of Delegates were largely attended. An unusual degree of interest and enthusiasm was manifested by the delegates, as well as the unusually large number of members who took occasion to witness the House of Delegates in action.

Realizing the serious responsibilities entrusted to them and the importance of the questions before them, the representatives of the county medical societies and academies of medicine deliberated calmly and studiously before taking action, carefully analyzing data submitted to them and listening to numerous viewpoints on all controversial questions.

The discussions provoked on some of the important questions indicated that the profession as a whole is well aware of the seriousness of the present conditions in public affairs as they affect scientific medicine and medical practice, and that it realizes concerted, harmonious and organized activity on the part of physicians is of greater importance now than ever before. Moreover, there was overwhelming evidence that the component county medical societies are for the most part alert, aggressive organizations and composed of men with the ability and force to solve questions of direct interest to the profession and affecting the health of the public.

The House of Delegates through its actions left no uncertainty as to the stand of organized medicine on matters affecting scientific medicine, medical practice and the public welfare. There was no hesitancy in setting forth clearly and definitely policies and procedures to guide the profession in Ohio in its dealings with other groups on social, economic and governmental questions affecting medicine and the health of the public. It repeatedly expressed confidence in the position organized medicine has taken with respect to important public questions and urged continued adherence to correct and proven policies. It emphasized the necessity and importance of concerted action and teamwork through established organization machinery.

Because of the meritorious and conscientious work of the various reference committees who spent many hours interviewing members and preparing reports, the business before the House of Delegates was transacted with efficiency and dispatch and the members provided with much valuable information previous to official action.

At the closing session of the House of Delegates, Dr. John A. Caldwell, Cincinnati, was installed by Dr. Cummer, as president for the ensuing year, and Dr. R. R. Hendershott, Tiffin, a former member of the Council and for many years exceedingly active in medical organization, was elected president-elect.

The following were elected to the Council for two-year terms: Dr. Parke G. Smith, Cincinnati, First District (re-elected); Dr. O. P. Klotz, Findlay, Third District (re-elected); Dr. A. A. Jenkins, Cleveland, Fifth District (new); Dr. C. W. Kirkland, Bellaire, Seventh District (new), and Dr. I. P. Seiler, Piketon, Ninth District (re-elected).

Election of delegates and alternates from the State Association to the House of Delegates of the American Medical Association for terms of two years, resulted as follows: Dr. Wells Teachnor, Sr., Columbus; alternate, Dr. Carl R. Steinke, Akron; Dr. Ben R. McClellan, Xenia; alternate, Dr. A. C. Messenger, Xenia; Dr. E. R. Brush, Zanesville; alternate, Dr. Gilbert Micklethwaite, Portsmouth; Dr. C. W. Stone, Cleveland, alternate, Dr. V. N. Marsh, Painesville.

Dr. Caldwell made the following appointments to the standing committees of the State Association, which were confirmed by the House of Delegates: Dr. J. H. J. Upham, Columbus, to succeed himself on the Committee on Public Policy and serve as chairman; Dr. Andrews Rogers, Columbus, to succeed himself as chairman of the Publication Committee; Dr. J. E. Tuckerman, Cleveland, to succeed himself as chairman of the Committee on Medical Defense; Dr. Ben R. McClellan, Xenia, to succeed himself as chairman of the Committee on Medical Education and Hospitals, and Dr. L. L. Bigelow, as a member and chairman of the Committee on Medical Economics.

The invitation of the Cincinnati Academy of Medicine to hold the 1935 meeting of the State Association in Cincinnati was accepted. Following a prolonged discussion regarding the best time for the next meeting, the House of Delegates instructed the Council to select a suitable time in the Fall of 1935.

* * * *

Much credit for the outstanding success of the Columbus meeting is due the members of the Columbus Academy of Medicine and especially the members of the various Columbus committees who had charge of handling the many details in connection with the meeting.

Under the efficient and untiring general chairmanship of Dr. L. L. Bigelow, assisted by Dr. V. A. Dodd, president of the Columbus Academy of Medicine, the various Columbus committees gave a splendid demonstration of what can be accomplished by teamwork and conscientious effort.

Their work was mapped out weeks in advance and synchronized in such a way that each committee was able to function with a minimum of effort but high degree of efficiency. All details from the largest to the smallest were carefully handled and everything possible done for the accommodation of those in attendance and those who took part in the program. Without proper coordination, wise selection of committeemen and plenty of enthusiasm and hard work on the part of each committee member, the 88th Annual Meeting would not have been the success it was.

Nothing short of perfection was the work of the Committee on Halls and Meeting Places, headed by Dr. J. W. Wilce. Delegated the important task of providing equipment, signs, adequate seating capacity, etc., for the various meeting halls, this committee with Dr. Wilce constantly on the job, turned in, so far as is known, a perfect record. As a result, there was a minimum of confusion in getting all sessions started and no delays or hitches in presenting the programs. All meeting places were effectively marked, greatly assisting those in attendance in finding section sessions with little or no bother. Praise and congratulations are due Dr. Wilce and his hard-working committee, consisting of Drs. K. H. Armen, Earl Baxter, J. E. Brown, Jr., N. C. Dysart, Edward Harris, John Horst, Morse F. Osborn, John Rauschkolb, Frank Riebel, L. W. Rohr, E. H. Ryan, Paul Scofield and Wynne Silbernagel.

Given the important, but usually disagreeable, job of providing and supervising projection apparatus for scientific speakers, the Projection Apparatus Committee under the chairmanship of Dr. C. C. Sherburne did a fine piece of work. Because of an increased demand for projection apparatus, the committee was hard-pressed to secure adequate equipment. However, when the meeting opened enough machines to meet every request were on hand and the details arranged so carefully, that a machine and operator always were on the job at the proper time and place. With one exception, which was the result of inefficiency on the part of one commercial operator, no difficulty was encountered. Those who worked with Dr. Sherburne and succeeded in putting the big, bad stereopticon jinx to rout were: Drs. H. F. Fulton, G. P. Sims and H. V. Weirauk.

Ingenuity, careful planning and a lot of hard work are required to make an affair such as the annual dinner an outstanding success and what it took to make this year's banquet a delightful and entertaining occasion was possessed in large quantities by the Entertainment Committee, headed by Dr. Russell G. Means, organizer de luxe. The fact that the banquet on Friday evening was a distinct success and acclaimed by those who attended as one of the finest ever held in connection with an Annual Meeting was a tribute to the work of Dr. Means and his committee, consisting of Drs. Aubrey B. Atkinson, Walter Hamilton, L. N. Jentgen, Ruth Koons Pereny, Link Murphy, E. J. Stedem, Wells Teachnor, Jr., and M. Grace Welch. Because this committee made its plans carefully, rolled up its sleeves and worked hard, there were no delays or miscues in the banquet or program which followed. The unanimous opinion was that everybody had a good time, plenty to eat and was well satisfied with the program.

The Reception Committee, headed by Dr. Dodd, president of the Columbus Academy of Medicine, was on the job constantly welcoming members and seeing that the out-of-state speakers were properly entertained. This committee consisted of Drs. J. F. Baldwin, J. E. Brown, Andre Crotti, E. J. Emerick, Fred Fletcher, Jonathan Forman, Geo. Heer, E. F. McCampbell, M. D. Miller, John H. Mitchell, H. M. Platter, Joseph Price, William H. Pritchard, C. J. Shepard, H. G. Southard, Wells Teachnor, Sr., and J. H. J. Upham.

Entertainment for women members and guests was arranged by a committee consisting of Dr. Edith Offerman, chairman, Dr. Isabell Bradley, Dr. Emilie Gorrell, Dr. Grace Jordan, Dr. M. Grace Welch and Dr. Charlotte Winnemore.

Elsewhere in this article will be found mention of several other committees in connection with some of the events which helped to make the Columbus meeting one of the best in the history of the State Association.

* * * *

Approximately 300 members and guests attended the annual dinner and dance on Friday evening in the main ballroom of the Neil House. During the dinner a floor show and instrumental concert were presented. Dr. L. L. Bigelow, a past president of the State Association and general chairman of the Columbus committees on arrangements, presided as toastmaster, welcoming the visiting physicians and presenting the speaker of the evening, Dr. Gus W. Dyer, professor of political science, Vanderbilt University.

Dr. Dyer, an entertaining speaker on all occasions, was at his best. Punctuating his address on 'Americanism", with samples of rare Tennessee mountaineer wit and philosophy, Professor Dyer traced in a fascinating fashion the history of constitutional government and analyzed the basic principles underlying American democracy.

He assailed without mincing words those striving to sweep aside principles on which the nation was founded; those who hope to substitute for them fantastic and dangerous theories of government, including regimentation and drastic regulation; and who are attempting to place unusual interpretations on provisions of the Constitution in efforts to solve pressing social and economic problems.

Professor Dyer pointed out that the American Constitution gives to the American citizen the

right to lead his own life, act for himself and think as his judgment indicates, restricting him only on matters which do harm to his fellow-men.

This principle is just as sound today as it was when the Constitution was drafted, he said, adding that it is not the business of government to tell people how to live, how to work, how much to pay or charge for commodities, where they shall live, but to see to it that they live and work in a respectable honest manner, without jeopardizing the interests of their neighbors.

The grave social, economic and governmental problems confronting the nation today, Dr. Dyer said, can be solved without repudiation of the concepts adhered to by the framers of the Constitution. Quoting from Thomas Jefferson that the best governed nation is that which is least governed, Dr. Dyer declared that the steady invasion of government into fields of private enterprise, its attempts to coerce the citizenry, and its inflated opinion that it can run the affairs of individuals better than they can, are rapidly breaking down American democracy which has elevated America to world leadership.

Deploring the increasing tendency on the part of an increasing number of people to look to government for support, he said: "Kings do not beg; true Americans are kings". Dr. Dyer blamed excessive paternalism and governmental invasion for the breakdown in the moral fiber of many citizens and the dissipation of their determination to shift for themselves and get along by individual initiative and enterprise.

Referring particularly to movements for socializing medical practice, Dr. Dyer urged members of the medical profession to stand united in opposition to governmental medicine and further invasion of government in the field of medicine. He declared socialization of medicine would be one of the most tragic events in American history, causing as it surely would deterioration in the quality of medical care, a collapse of ethical and moral concepts, and regimentation of those engaged in a type of work where personal judgment, individual initiative and confidential personal relationships are essential factors.

* * * *

Preliminary to the opening of the Annual Meeting, an elaborate program of medical and surgical clinics and demonstrations was presented at Columbus hospitals by members of the Columbus Academy of Medicine on Wednesday morning and afternoon and Thursday morning.

The program, arranged by Dr. Fred Fletcher and his Clinics Committee, consisting of Drs. E. H. Baxter, Andre Crotti, Charles A. Doan, I. B. Harris, Joseph Price, W. P. Smith and Charles E. Turner, was conceded to have been one of the most varied and educational demonstrations of this kind ever arranged for Annual Meeting guests.

Those who arrived in time to attend the clinics were loud in their praise of the work done and the careful selection of subjects. However, the attendance at most of the clinics was disappointing, undoubtedly due to the fact that a great majority of those attending the meeting motored to Columbus on Thursday morning immediately preceding the opening session.

There was general agreement among many of the members that in the future local hospital clinics should either be included as a part of the Annual Meeting program or should not be arranged, since a meager attendance does not justify the time and effort given by those presenting the clinics and the committee delegated the tedious work of arranging them.

The institutions where clinics were held and those who presented them are as follows:

Children's Hospital—Dr. O. L. Baldwin, Dr. C. A. Aldrich, Dr. E. H. Baxter, Dr. E. H. Wilson, Dr. John E. Brown, Jr., and Dr. J. E. Briggs.

Grant Hospital—Dr. Andre Crotti, Dr. Hugh Baldwin, Dr. A. M. Steinfeld, Dr. H. P. Worstell, Dr. I. B. Harris, Dr. Frank W. Harrah, Dr. S. J. Goodman.

Mercy Hospital—Dr. Joseph Price, Dr. John Wenzke and Associates.

Mt. Carmel Hospital—Dr. George P. Sims, Dr. H. F. Fulton, Dr. C. E. Turner and Associates, Dr. C. S. Hamilton, Dr. Wells Teachnor, Jr., Dr. H. H. Yoakem, Dr. Wells Teachnor, Sr., Dr. E. J. Stedem, Dr. Andre Crotti, Dr. H. O. Bratton, Dr. E. W. Troutman.

St. Francis Hospital—Dr. Russell G. Means, Dr. L. H. Van Buskirk, Dr. C. C. Sherburne, Dr. T. E. Rardin, Dr. S. J. Goldstein, Dr. I. B. Harris, Dr. Luke Zartman.

University Hospital—Dr. V. A. Dodd and staff, Dr. John W. Means, Dr. Jack Taylor, Dr. H. G. Beatty, Dr. E. W. Harris, Dr. George M. Curtis, Dr. Paul Charlton, Dr. S. D. Edelman, Dr. Mary Graber, Dr. E. G. Horton, Dr. E. H. Baxter, Dr. Andrews Rogers, Dr. G. I. Nelson, Dr. Philip Kriess, Dr. Frank Wagenhals, Dr. John E. Brown, Jr., Dr. Versa Cole, Dr. C. A. Doan, Dr. Hargraves, Prof. F. A. Hartman, Dr. Puppel, Dr. Fred Fletcher, Dr. Philip Reel, Dr. Russell G. Means, Dr. B. K. Wiseman, Dr. C. V. Moore, Prof. W. A. Starin, Norman Mathews, Dr. A. D. Frost, Dr. Harlan Wilson, Dr. S. A. Hatfield, Dr. E. G. Gordon, Dr. Lowenstein, Dr. Louis Barron.

White Cross Hospital—Dr. Fred Fletcher, Dr. Ned Kirkendall, Dr. William P. Smith, Dr. Carl D. Hoy, Dr. E. C. Ludwig, Dr. W. F. Millhon, Dr. R. W. Kissane, Dr. R. S. Fidler, Dr. H. V. Weirauk, Dr. Frank Warner, Dr. W. D. Inglis, Dr. E. H. Chapin, Dr. C. S. Perry, Dr. Wynne Silbernagel, Dr. John Hoberg, Dr. Louis Mark, Dr. H. E. Boucher and Dr. W. E. Masters.

* * * *

One of the special features of the meeting which attracted an unusual amount of interest was the Scientific Exhibit which occupied two large rooms at the rear of the west corridor of the mezzanine floor.

The excellent manner with which the subjects were displayed and the attractiveness of the lay-

outs and booths brought forth considerable favorable comment from many among the hundreds who visited the exhibit.

Much time and effort on the part of the exhibitors and the local Committee on Scientific Exhibits were necessary to make the exhibit the success it actually was and for which they deserve appreciation and credit. The personnel of the committee was: Dr. George I. Nelson, chairman, Dr. R. S. Fidler, Dr. E. J. Gordon, Dr. R. W. Hoffman, Dr. E. G. Horton, Dr. P. J. Reel and Dr. H. L. Reinhart.

The following exhibits were displayed:

Bilateral Hare Lip Repair, Dr. D. M. Glover, St. Luke's, Lakeside, and City hospitals, Cleveland.

Allergy, Dr. Milton B. Cohen, Cleveland.

Indications and Methods for Surgery of Periocardium, illustrated with motion pictures, Dr. Claude S. Beck, Lakeside Hospital, Cleveland.

Encephalography, Dr. H. D. Piercy, Cleveland.

X-ray Exhibits of Pulmonary Lesions, Dr. Frank C. Anderson, Ohio State Sanatorium, Mt. Vernon.

Asymmetry of Nares and Dislocation of Lower End of Septal Cartilage in the Newborn and in Young Children, Dr. Myron Metzenbaum, Cleveland.

Diagnosis and Management of Urinary Calculi, Dr. C. C. Higgins, Cleveland.

Gall Bladder and Common Duct Diesases, Dr. Fred M. Douglass, Toledo.

Allergy, Dr. Jonathan Forman and Dr. John Mitchell, Columbus.

Collapse of the Lung, Dr. Herman Shube, Cleveland.

Public Health Services, State Department of Health, Columbus.

* * *

When it comes to handling a complicated meeting such as the Annual Meeting of the State Asosociation, the Neil House has no peer. Because of the exceptional layout afforded by the Neil House for large meetings, especially those with sectional meetings and exhibits, meetings held there are practically certain to proceed with a minimum of confusion and difficulty. Under the generalship of the ever-courteous, ever-accommodating and ever-calm Tom Sabrey, the Neil House staff takes convention hurdles without missing a step and always comes through with colors flying. Mr. Sabrey's well-trained aides were on the job at all times and never seem to make a slip. Their cooperation and assistance were big factors in the smoothness with which the Annual Meeting arrangement machinery functioned. The Neil House, its management and its staff deserve the praise given them for the way they helped set the stage for the successful Columbus meeting and for the excellent treatment accorded the physicians of Ohio.

* * *

The commercial exhibits which occupied the spacious lounge across the east side of the mezzanine floor were never better, in the opinion of many. Although a fewer number of firms exhibited than is customary for a Columbus meeting, the shortage in quantity was more than offset by the high quality of the exhibit set-up. There was a unanimity of opinion among the exhibitors that the 1934 meeting was one of the best in the history of the Association. Being keen judges of what is or is not a successful meeting, their opinions must be respected, which is to say—the Columbus meeting was a success.

* * *

Excellent coverage of the meeting was given by the Columbus newspapers and able assistance rendered by the Convention's Bureau of the Columbus Chamber of Commerce to the local committees in arranging details for the gathering, and in furnishing experienced personnel for the registration.

* * *

A number of class fraternity reunions and luncheons were held during the meeting. A luncheon for women physicians, held Friday noon, was arranged by the Columbus Committee on Women's Entertainment. On the same day, the alumni of Vanderbilt University Medical School held a luncheon at the Athletic Club, honoring Professor Dyer. Several of the classes of Ohio State University, College of Medicine, held reunions as did Ohio unit of the Medical Veterans' Association.

— OSMJ —

New Books Received

Physical Diagnosis, by Richard C. Cabot, M.D., professor of clinical medicine emeritus, Harvard Medical School; eleventh edition; revised and reset throughout, with numerous data on a variety of important subjects; William Wood & Company, Baltimore, publishers; price, $5.00.

The Anatomy of Surgical Approaches, by L. C. Kellogg, M.D., professor of anatomy, College of Medical Evangelists, Los Angeles; a treatise planned to give the surgeon accurate landmarks which will guide him in carrying out surgical procedures not so commonly performed, accompanied by laboratory directions; William Wood and Company, Baltimore, publishers; price, $1.50.

Electrocardiography, by Chauncey C. Maher, M.D., assistant professor of medicine, Northwestern University; a volume for use by the general practitioner, medical student and specialist, exclusive of the cardiologist, emphasizing the value of the electrocardiogram and explaining how to correlate the findings with clinical data; William Wood and Company, Baltimore, publishers; price, $4.00.

Conception Period of Women, by Kyusaku Ogino, M.D., head of the gynecological section, Takeyama Hospital, Niigata, Japan; Medical Arts Publishing Company, 1803 Wood Street, Harrisburg, Pa., publishers; price, $1.00.

PROBLEMS OF POLICY, LEGISLATION AND MEDICAL DEFENSE PRESENTED AT ORGANIZATION LUNCHEON

One of the most inspiring events in connection with the 88th Annual Meeting in Columbus was the Organization Luncheon held on Friday noon, October 5, in the main dining room of the Neil House.

Over 200 presidents, secretaries, treasurers, legislative committeemen, and medical defense committeemen of the component county medical societies and academies of medicine; officers, Councilors, former presidents, and members of the standing and special committees of the State Association; officers of the Scientific Sections, and members of the House of Delegates were in attendance.

The enthusiasm and interest displayed in the excellent discussions of important questions involving matters of public policy and medical defense presented by Dr. C. W. Stone, Cleveland, chairman of the Committee on Public Policy, and Dr. J. E. Tuckerman, Cleveland, chairman of the Committee on Medical Defense, clearly indicated that the leadership of medical organization is in thoroughly competent hands and that organized medicine is well prepared to take an aggressive role in all public affairs having a bearing on medical and health questions.

Dr. C. L. Cummer, Cleveland, the President, presided and introduced to the gathering, Dr. John A. Caldwell, Cincinnati, the incoming president; Dr. H. M. Platter, Columbus, the past president; Dr. Ben R. McClellan, Xenia, chairman of the Committee on Medical Education and Hospitals; Dr. J. Craig Bowman, Upper Sandusky, chairman of the Committee on Medical Economics; Dr. Andrews Rogers, Columbus, chairman of the Publication Committee; Dr. J. H. J. Upham, Columbus, chairman of the Board of Trustees of the American Medical Association and a member of the Committee on Public Policy of the State Association, and Dr. Stone and Dr. Tuckerman, the luncheon speakers. The informal, but instructive and valuable, talks made by Dr. Stone and Dr. Tuckerman constituted a fitting climax to what, in the opinion of many in attendance, was one of the best Organization Luncheons ever held by the State Association.

VITAL LEGISLATIVE PROBLEMS ANALYZED

Dr. Stone in his usual concise, direct and logical manner, summarized some of the vital problems which confront the medical profession, especially organized medicine whose duty is to represent the interests of the profession in public affairs, and suggested ways of dealing with these problems.

Pointing out that one of the most serious questions before the medical profession is that arising from the agitation for medical care at public expense regardless of the economic status of the recipients of such service, Dr. Stone said:

"If and when legislation is enacted to provide such medical service to the public, you can readily see the altered status of the physician, economically, socially, and scientifically. There are those who fondly hope and believe that such legislation is possible with the coming session of Congress. We see numerous indications that the program of social activities and benefits, originally inaugurated as temporary and emergency, is to be expanded and made permanent. Spokesmen for the national government have indicated that further socialization of medicine, at least to the extent of compulsory state health insurance, would be a part of the New Deal program of social insurance and social security. It is understood that a well organized welfare group is contacting legislative candidates in Ohio with propaganda for complete governmental medicine.

Dr. Stone called attention to the fact that because of the present tendency for experimentation and governmental changes through radical enactment, anti-medical forces, including cultists, groups of limited practitioners and others who have persistently sought to destroy public health administration and sound laws and regulations governing medical practice, are even more aggressive now than in previous years.

Likewise, he outlined briefly other controversial questions, affecting physicians as individuals and citizens, which promise to produce heated and bitter clashes during the regular session of the Ohio General Assembly in 1935. He mentioned particularly the subject of taxation, pointing out that new tax proposals will be made which may affect all physicians and that such proposals must be considered from the viewpoint of avoiding a duplication of tax impositions on physicians.

EFFECTIVE METHODS AND ACTIVITIES OUTLINED

Explaining why these matters were enumerated and suggesting practical and effective methods which should be employed by organized medicine and physicians as individuals in dealing with public questions, including legislation, Dr. Stone said:

"These past, present and future difficulties are cited to suggest that physicians as citizens should

take an active interest not only in the problems of governmental administration, but in the cost of government and how the revenue for its operation is raised. Contemplate whether it is desirable to pick well-qualified men to represent you in the legislative bodies.

"The medical profession, through years of experience, is in a position to be of service to legislators with information and advice. A personal interview with each candidate who has a chance to be elected should be arranged by the legislative committeeman of each and every medical society. If not personally known to the candidate, he should be accompanied by the family physician or a close medical friend of the candidate, and together they should discuss some of the general policies of medical organization. The object, of course, is to suggest to such candidates that they should look to the medical profession, through medical organization, as a proper source for authoritative information and advice on legislation pertaining to public health, scientific medicine, and medical practice. In all contacts it is well to emphasize that the policy and attitude of the medical profession is based on proper consideration for the public good, and that a competently trained, professionally minded type of physician is essential to public safety, public health, public welfare and individual security."

POLICY AGAINST ENDORSEMENTS CITED

Dr. Stone emphatically called attention to the established policy of the State Association against action by county medical societies or the State Association officially endorsing, opposing or promoting the candidacies of those seeking public office. However, he stated with equal emphasis that physicians as individuals and citizens can with propriety discuss such questions and take such action as their judgment indicates.

It was pointed out by Dr. Stone that legislators and other public office holders develop their attitude and opinions largely through local contacts and situations and from sentiments expressed by their local constituents. For that reason, he said, it is important that the medical profession in each county take an active interest in political, governmental and legislative matters and develop a sound medical viewpoint among the candidates and office holders in their community.

In conclusion Dr. Stone declared the medical profession must accept the challenges facing it and meet its critics and enemies with a well-developed counter-attack.

"If the medical profession is to be successful in avoiding or overcoming the dangers it is facing it must be united and forceful in its activities, and sound and tactful in its judgments. In this present crisis when the states are no longer sovereign and the federal government has become master of the people, it is a patriotic duty to become politically minded. There must be a return to constitutional democracy with proper safeguards to prevent a recurrence of the present situation, or there must be a further shift to the left and a frank acceptance by the American people of either a type of dictatorship or communism. Physicians in every community, as leading citizens, can exert an important influence on public affairs. Let us do our part."

* * * *

Dr. Tuckerman in his brief, but timely and illuminating, remarks on the causes of suits and threats of suits for alleged malpractice and the importance and value of the medical defense plan of the State Association gave the luncheon audience plenty to think about.

Illustrating his talk with pertinent examples from the records of the Committee on Medical Defense of which he has been chairman for many years, Dr. Tuckerman drove home the point that the medical profession can blame itself for many of the serious situations and much of the unpleasantness resulting from malpractice suits and threats.

Basing his opinions on his long experience in investigating and assisting in preparation of defenses for such suits, Dr. Tuckerman said that the great majority of malpractice actions are the result of some thoughtless, jealous or malicious statement on the part of some physician and that few are justified by facts and circumstances.

"I cannot impress upon all physicians too strongly to avoid engaging in the gentle art of knocking," Dr. Tuckerman said.

While advocating close adherence to the warning "silence is golden", he cautioned against assuming an attitude of "superior silence", pointing out that diplomatic side-stepping is always the best course for a physician to pursue if there is any doubt as to the motives of an individual seeking information on the qualifications or work of some other physician, or the circumstances indicate dissatisfaction with services rendered by him.

THOUGHTLESS, BUT COSTLY REMARKS

Dr. Tuckerman cited several examples of how thoughtless or careless remarks dropped by a physician while attending a patient had returned to plague him in the form of a malpractice suit or had sown seeds of dissatisfaction in the patient's mind concerning treatment received from some other physician, ultimately resulting in the filing of an action against the other practitioner.

DO'S AND DONT'S ENUMERATED

Dr. Tuckerman enumerated some of the things the physician should keep in mind in dealing with patients to minimize the chances of subsequent suits for alleged malpractice and strengthen his defense in event of suit as follows:

"A dissatisfied patient is like a stick of dynamite. Get rid of him as quickly as possible but,

of course, be certain you have established proper legal safeguards and that his condition indicates dismissal before you tell him to get another doctor.

"Keep adequate records of all cases.

"Remember that the indigent person is a dangerous patient. A large proportion of those seeking malpractice judgments from physicians are indigent.

"Keep in mind that a minor is an additional risk. In treating a child, be extremely careful with your records and never fail to see that the child's parents or guardian are fully informed regarding his condition and the course of treatment given.

"Fracture cases are always dangerous. They are the type of case upon which the majority of malpractice suits are based. Get an *X*-ray of all fracture cases if humanely possible. Refuse to handle the case rather than permit the patient to refuse an *X*-ray.

"Remember that the physician has no property rights in any patient. He is your patient simply because he wants to be and can leave you anytime he wants to."

VALUE OF DEFENSE PLAN

Dr. Tuckerman emphasized the value of the medical defense plan in preventing malpractice suits and in defending physicians when sued, pointing out that no physician can afford to let his good standing in medical organization lapse and therefore become ineligible to participate in the medical defense plan.

In conclusion, Dr. Tuckerman criticized the increasing tendency on the part of some physicians and insurance companies to compromise malpractice actions and to settle suits regardless of the facts and circumstances. He also termed as "unfortunate" the seeming willingness of some physicians to hire themselves as expert witnesses to plaintiffs in malpractice suits, with little or no consideration for the evidence or circumstances involved in the cases on which the suits are based.

SPLENDID ATTENDANCE AT THE ANNUAL MEETING IN COLUMBUS ≈≈≈ THE REGISTRATION

The remarkable attendance at the 88th Annual Meeting in Columbus was one of the most significant signs recorded at the meeting indicating a continuance of concerted active interest on the part of the medical profession of the state in the program and functions of the State Association during the ensuing year and the appreciation of most physicians of the value of and benefits to be derived from effective and efficient organized activity.

Despite prevailing business conditions and the fact that several important medical meetings, including the annual session of the American Medical Association, had been held in Ohio during the year, the Columbus meeting drew an attendance that surpassed expectations and was exceptional when compared to the registration figures reported during the past year at meetings of similar professional and business organizations.

The total registration at Columbus, including members of the State Association, guests, out-of-state physicians and exhibitors, was 1539, exceeding by several hundred the average total registration for the past 16 Annual Meetings.

Members who attended and registered totaled 1069, a splendid showing in view of a series of circumstances that made it impossible for some members to attend.

The registration of guests, including internes, medical students, nurses, and women visitors, was 410.

Nine out-of-state physicians were in attendance and registered.

Fifty-one exhibitors were registered, exceeding the number registered for the three previous Annual Meetings.

The following tabulation for the past succeeding 16 Annual Meetings shows by comparison the members, out-of-state physicians, guests and exhibitors registered and the total registration for each meeting:

Year	Place	Members	Out-of-State Physicians	Guests	Exhibitors	Total
1919	Columbus	1173	10	264	92	1529
1920	Toledo	810	17	105	80	1062
1921	Columbus	1275	28	204	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1116
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539

MEMBERSHIP REGISTRATION

The list of members registered, by counties, follows:

Adams—J. M. Brooke, S. J. Ellison, R. B. Ellison, F. C. Leeds, Hazel Sproull, O. T. Sproull, Ray Vaughen. *Allen*—I. D. Baxter, Ezra Burnett, Geo. Hartnagel, J. R. Johnson, Walter A. Noble, W. V. Parent, O. S. Robuck, John J. Sutter, F. G.

Stueber, T. R. Terwilliger, J. R. Tillotson, A. N. Wiseley.

Ashland—Herman M. Gunn, George Riebel. *Ashtabula*—R. B. Wynkoop. *Athens*—D. H. Biddle, T. A. Copeland, A. J. Crawford, C. H. Creed, M. N. Fowler, John C. Henry, J. L. Henry, J. M. Howard, W. E. Howe, Charles S. McDougall, J. T. Merwin, M. H. Mitchell, H. T. Phillips, A. L. Pritchard, L. D. Robinson, C. E. Welch.

Auglaize—Charles C. Berlin, E. F. Heffner, R. C. Hunter, Guy E. Noble, Harry S. Noble, S. H. Sibert. *Belmont*—D. M. Creamer, F. R. Dew, C. W. Kirkland. *Butler*—Mildred White Gardiner, Wilmer E. Griffith, William H. Henry, Mark Millikin, Mildred L. Snyder, E. T. Storer, Edward L. Wilkinson.

Champaign—D. C. Houser, Forrest E. Loury, W. H. Sharp, L. A. Woodburn, V. G. Wolfe, W. A. Yinger. *Clark*—F. P. Anzinger, Roy D. Arn, J. E. Burgman, M. S. Collins, J. C. Easton, A. A Gavey, E. P. Greenawalt, Delos W. Hogue, Clarence W. Hullinger, S. R. Hutchings, J. A. Link, C. L. Minor, Wm. B. Quinn, Bennetta D. Titlow, Will Ultes. *Clermont*—Allan B. Rapp.

Clinton—E. C. Briggs, Robert Conard, Kelley Hale, C. E. Kinzel, A. C. Roberts, W. T. Scott, Elizabeth Shrieves, C. A. Tribbett. *Columbiana*—J. F. Elder. *Coshocton*—J. C. Briner, R. E. Hopkins, H. H. Schwindt, J. G. Smailes. *Crawford*—Clarence Adams, D. G. Arnold, K. H. Barth, Charles J. Griebling, H. H. Hartman, Mart Helfrich, C. A. Lingenfelter, R. M. Malone, Charles E. Trimble, W. Lewis Yeomans.

Cleveland and Cuyahoga County—W. R. Barney, Claude S. Beck, A. J. Beams, Donald C. Bell, W. T. Bennie, Charles A. Bowers, L. R. Brigman, A. B. Bruner, Charles W. Burhans, H. Van Y. Caldwell, Milton B. Cohen, John W. Conwell, J. T. Collins, C. L. Cummer, A. G. Cranch, John Hart Davis, W. L. Deeton, John Dickenson, Ralph S. Dial, Fred W. Dixon, H. H. Drysdale, W. P. Edmunds, Joseph Fetterman, Warren C. Fargo, F. W. D. Finke, Ida E. Fleming.

Wm. D. Fullerton, W. James Gardner, Henry J. Gerstenberger, Frank S. Gibson, D. M. Glover, Russell L. Haden, Karla P. Hahn, F. C. Herrick, Louis J. Karnosh, H. C. Kelker, C. H. Heyman, Charles C. Higgins, Arthur J. Horesh, Samuel Hurwitz, Theron S. Jackson, A. A. Jenkins, Henry J. John, Thomas E. Jones, Hubert C. King, E. Klaus, Harold J. Knapp, Lester W. Krauss, Paul H. Krebs, C. G. LaRocco, John E. Linden, George H. Lewis, A. Loveman.

O. B. Markey, M. I. Marks, J. E. McClelland, Myron Metzenbaum, Theodore Miller, Paul G. Moore, Harry V. Paryzek, Clayton C. Perry, H. D. Piercy, A. J. Prudhomme, Rudolph S. Reich, V. C. Rowland, E. D. Sanders, Henry C. Schumacher, J. J. Selman, Dr. Herman Shube, Alvin O. Sibila, Harry G. Sloan, A. J. Skeel, Charles W. Stone, G. F. Sykes, John A. Toomey, J. E. Tuckerman, Guy H. Williams, C. E. Ward.

Darke—W. D. Bishop, E. G. Husted, J. E. Hunter, F. M. Kissell, B. F. Metcalfe, A. F. Sarver, J. O. Starr, C. I. Stephen, O. P. Wolverton. *Defiance*—D. J. Slosser. *Delaware*—E. V. Arnold, O. W. Bonner, W. E. Borden, M. S. Cherington, D. S. Cowles, M. W. Davies, L. M. Ihle, Floyd V. Miller, G. E. Robinson, C. F. Talley, F. M. Stratton, George Y. Swickard. *Erie*—R. E. Garnhart, J. C. Kramer.

Fairfield—G. O. Beery, A. O. Brown, Carl W. Brown, W. R. Coleman, J. T. Farley, C. H. Hamilton, A. M. Kelley, A. V. Lerch, H. R. Plum, E. B. Roller, Ralph H. Smith, L. E. Stenger, W. B. Taylor, K. W. Taylor, J. W. Whittus, William E. Wiyiarch. *Fayette*—L. L. Brock, J. M. Harsha, E. H. McDonald, Lucy W. Pine, A. S. Stemler, E. F. Todhunter, James F. Wilson, Orlyn Wiseman, A. D. Woodmansee.

Columbus and Franklin County—B. W. Abramson, J. Garfield Alcorn, Nicholas A. Albanese, F. P. Atkinson, K. H. Armen, E. S. Anderson, Shirley Armstrong, Orville L. Baldwin, J. F. Baldwin, E. H. Baxter, Hugh A. Baldwin, Paul R. Bauman, Henry A. Baughn, James A. Beer, C. H. Benson, H. C. A. Beach, Hugh G. Beatty, J. E. Beery, E. C. Beam, L. L. Bigelow, Halbert B. Blakey, R. W. Bonnell, G. H. Bonnell, H. E. Boucher, W. D. Bower, Audrey Bowers-Atkinson, J. W. Brobst, Wayne Brehm, Isabel A. Bradley, John Edwin Brown, Sr., John Edwin Brown, Jr., J. E. Briggs, H. O. Bratton, Richard I. Brashear, H. M. Brundage, D. V. Burkett.

E. E. Campbell, A. S. Canowitz, J. S. Carlton, P. H. Charlton, Fred S. Clark, I. G. Clark, Kenneth A. Clouse, E. H. Chapin, C. W. Conley, Geo. W. Cooperrider, D. W. Collison, O. L. Coddington, J. J. Coons, George Curtis, Andre Crotti, Drew L. Davies, Wm. C. Davis, Deane D. Davis, Francis W. Davis, Verne A. Dodd, H. H. Dorr, C. A. Doan, J. Q. Dorgan, John Dudley Dunham, A. H. Dunn, Robert H. Dunn, N. C. Dysart.

E. J. Emerick, S. D. Edelman, Charles W. Edwards, H. D. Emswiler, A. J. Enderlin, Earl W. Euans, J. P. Farson, R. S. Fidler, T. R. Fletcher, Fred Fletcher, Jonathan Forman, Clarence Fry, C. F. Frosh, Albert D. Frost, Huston F. Fulton, James M. Foley, J. M. Gettrost, F. T. Gallen, Sylvester J. Goodman, Milton L. Goodman, F. W. Gosnell, H. D. Giles, E. J. Gordon, David B. Gilliam, Emilie C. Gorrell, F. E. Ginder, Mary A. Graber, M. Hajos, Augustus A. Hall, F. E. Hall, Edwin A. Hamilton, Frank E. Hamilton, Walter H. Hamilton.

F. C. Haney, E. W. Harris, H. K. Harris, H. L. Harris, I. B. Harris, Louis M. Harris, R. R. Harris, George T. Harding, Earl L. Harney, Frank W. Harrah, S. A. Hatfield, Arthur M. Hauer, Emery R. Hayhurst, F. A. Heckler, George J. Heer, E. D. Helfrich, A. G. Helmick, E. Herbst, Louis T. Hess, John E. Hoberg, Charles H. Hoffhines, J. E. Holmes, E. G. Horton, S. M. Horen, George O. Hoskins, C. DaCosta Hoy, Wm. A. Humphrey, Carl A. Hyer.

W. D. Inglis, Jessie Jasper, L. N. Jentgen, A. Beaumont Johnson, A. H. Kanter, Max P. Kanter, R. R. Kahle, G. W. Keil, F. L. Keiser, J. E. Kerschner, R. A. Kidd, Sr., R. A. Kidd, Jr., C. C. Kirk, E. T. Kirkendall, Herman W. Koerper, Ruth A. Koons, M. A. Krakoff, Roy E. Krigbaum, Albert B. Landrum, John W. Larcomb, Leonard F. Lauf, H. E. LeFever, F. F. Lawrence, G. P. Lawrence, Ruskin B. Lawyer, W. E. Lloyd, E. C. Ludwig, Harley Sherman Manuel, Louis Mark, Olin R. Martin, W. Eugene Masters.

E. F. McCampbell, A. B. McConagha, C. W. McGavran, Charles A. McDonald, John McLaughlin, Hugh J. Means, John W. Means, Russell G. Means, M. E. Millhon, Wm. F. Millhon, D. A. Minder, Myron D. Miller, H. R. Mitchell, John H. Mitchell, Dickson L. Moore, W. B. Morrison, Richard S. Moynan, Link Murphy, G. I. Nelson, G. B. Nessley, Robert W. Nosker, A. W. Oelgoetz, W. E. Obetz, Edith M. Offerman, John W. Parker, Charles W. Pavey, Claude L. Perry, E. F. Peinert.

H. M. Platter, C. D. Postle, W. H. Pritchard, William L. Pritchard, Andrew W. Prout, Daniel J. Price, Joseph Price, R. A. Ramsey, T. E. Rar-

din, J. Rauschkolb, M. E. Reeder, Harry L. Reinhart, Philip J. Reel, Edward Reinert, W. S. Rhodes, Frank Riebel, J. A. Riebel, Rush Robinson, Andrews Rogers, R. A. Rogers, L. W. Rohr, C. C. Ross, Paul S. Ross, O. L. Rosenow, L. J. Roth, Maurice B. Rusoff, E. H. Ryan.

D. G. Sanor, Thomas D. Santurello, A. H. Sealy, E. R. Shaffer, Clark E. Sharp, Charles J. Shepard, C. M. Shepard, I. W. Sherwood, C. C. Sherburne, E. R. Shilling, A. J. Shoemaker, Wynne M. Silbernagel, George P. Sims, Clayton S. Smith, Wm. P. Smith, C. L. Spohr, G. H. Snyder, C. H. Solomonides, J. C. Sommer, F. M. Stanton, E. J. Stedem, M. F. Steele, J. S. Stevens, A. M. Steinfeld, A. R. Stone, J. A. Stout, W. A. Stoughton, Wm. A. Stoutenborough, Ralph B. Taylor, Sterling B. Taylor, Wells Teachnor, Berger Thomas, Francis W. Thomas, John M. Thomas, J. A. Thone, E. A. Thrall, E. W. Troutman, Charles E. Turner.

J. H. J. Upham, L. H. Van Buskirk, A. L. Van Horn, Finley Van Orsdall, Thomas A. Vogel, F. C. Wagenhals, Frank Warner, James H. Warren, Fred H. Weber, M. Grace Welch, C. H. Wells, Howard Whitehead, H. O. Whitaker, J. W. Wilce, P. B. Wiltberger, Perry W. Willey, E. H. Wilson, J. D. Wilson, Joseph C. Williamson, Charlotte Winnemore, T. Rees Williams, B. K. Wiseman, Roy C. Wolcott, H. P. Worstell, C. H. Wyker, Luke V. Zartman.

Gallia—Mary L. Austin, Leo C. Bean. *Greene*—Paul D. Espey, W. C. Marshall, Ben R. McClellan, Reyburn McClellan, C. G. McPherson, A. C. Messenger, H. C. Messenger, T. F. Myler, Harold E. Ray, C. E. Ream, A. D. Ritenour, L. L. Taylor, A. N. Vandeman, Wm. T. Ungard, A. B. Wingfield. *Guernsey*—W. L. Denny, C. C. Headley, F. Gordon Lawyer, A. G. Ringer, George F. Swan.

Cincinnati and Hamilton County—J. F. Bateman, Samuel Brown, John A. Caldwell Ralph G. Carothers, Robert Carothers, George E. Clarke, H. F. Conwell, David J. Davies, Edwin W. Enz, Louis Feid, Jr., Carroll J. Fairo, Lloyd King Felter, Henry B. Freiberg, Lee Foshay, Albert H. Freiberg, Mabel E. Gardner, Ralph Wm. Good, Henry M. Goodyear, Samuel Goldblatt.

J. Victor Greenebaum, Daniel C. Handley, C. E. Hauser, W. Morse Hicks D. A. Johnston, Lloyd B. Johnston, Charles E. Kiely, Edward King, Daniel J. Kindel, J. Arthur Leary, Louis A. Lurie, Robert A. Lyon, Gilbert Mombach, Charles A. Neal, Emerson A. North, D. W. Palmer, C. A. Price, Wm. D. Porter, Helena T. Ratterman, Mont R. Reid, Robert C. Rothenberg, Samuel Rothenberg, Clyde S. Roof.

L. Howard Schriver, Otto Seibert, Parke G. Smith, J. Glen Smith, S. D. Simon, Charles T. Souther, Cecil Striker, Emil R. Swepston, Paul W. Sutton, E. O. Swartz, H. F. Tangeman, A. R. Vonderahe, A. Wigser, Charlotte Weidemer, H. L. Woodland, M. M. Zinninger.

Hancock—J. M. Firmin, D. J. King, O. P. Klotz, Russell E. McBroom, Ralph E. Rasor. *Hardin*—F. M. Elliott, J. P. Gibson, C. L. Johnson, R. C. McNeill, D. R. Printz, E. S. Protzman, R. G. Schutte, G. S. Wilcox. *Henry*—C. M. Harrison, Arnold D. Piatt. *Highland*—W. H. Ambrose, J. C. Bohl, Hugh W. Chaney, J. H. Frame, J. B. Glenn, H. H. Lowe, W. B. Roads T. W. Roberds, K. R. Teachnor. *Hocking*—H. M. Boocks, M. H. Cherrington, J. S. Cherrington, James D. Francis, W. B. Lacock, J. L. Webb.

Holmes—A. T. Cole, J. C. Elder. *Huron*—O. J. Nicholson. *Jackson*—J. S. Hunter, J. J. McClung, O. M. McLaughlin, A. G. Ray. *Jefferson*—John Y. Bevan, Victor Biddle, George F. Gourley, S. A Harris. *Knox*—Ernest V. Ackerman, F. C. Anderson, Harry M. Butler, John C. Drake, Robert L. Eastman, S. O. Gantt, C. L. Harmer, George B. Imhoff, Joseph D. Landesman, J. M. Pumphrey, O. W. Rapp, William I. Sharp, Julius Shamansky, Irvin S. Workman.

Lake—Robert E. Gardner, V. N. Marsh. *Lawrence*—E. E. Ellsworth, O. H. Henninger, W. Wilson Lynd. *Licking*—H. B. Anderson, T. Leland Baxter, C. G. Bozman, Geraldine H. Crocker, J. N. Cross, C. J. Dillon, R. G. Downs, W. L. Evans, George A. Gressle, W. E. Hopkins, R. C. Mauger, John R. McClure, J. Fleek Miller, Louis A. Mitchell, E. A. Moore, Thomas E. Morgan, W. H. Morgan, Harry H. Postle, Geo. W. Sapp, Victor R. Turner, Donald E. Yochem.

Logan—Omar C. Amstutz, R. A. Firmin, J. P. Harbert, F. R. Makemson, C. K. Startzman, Lee E. Traul. *Lorain*—S. V. Burley, Benjamin Carlson, A. S. McKitrick, Charles R. Meek, George Mynchenburg.

Toledo and Lucas County—W. W. Brand, Robert B. Curl, Fred M. Douglass, Paul R. Ensign, John Gardiner, E. B. Gillette, Norris W. Gillette, Stanley D. Giffen, Barney J. Hein, H. F. Howe, Paul M. Holmes, I. H. Kass, A. J. Kuehn, L. A. Levison, Charles Lukens, Louis A. Miller, Nelson Morris, F. N. Nagel, W. A. Neill, F. W. Pilliod, Harry M. Scott, P. G. Tait, C. W. Waggoner, John F. Wright.

Madison—R. W. E. Irwin, F. A. Lutz, J. M. Morse, F. E. Rosnagle, C. G. Scheetz. *Mahoning*—W. H. Bunn, C. H. Campbell, L. G. Coe, George Y. Davis, Morris Deitchman, W. H. Evans, J. E. Keyser, Sidney McCurdy, R. B. Poling, Wm. M. Skipp, A. C. Tidd, O. J. Walker.

Marion—M. F. Axthelm, C. L. Baker, D. W. Brickley, E. L. Brady, Bret B. Hurd, J. W. Jolley, S. W. Mattox, R. T. Morgan, H. K. Mouser, B. D. Osborn, Robert Ramroth, Herman S. Rhu, Carl W. Sawyer, C. G. Smith, M. Sifrit, A. A. Starner. *Medina*—E. L. Crum, James K. Durling, Frank W. Knittel, H. P. H. Robinson.

Meigs—Byron Bing, R. E. Boice, H. M. Crumley. *Mercer*—John T. Gibbons, Paul E. Rex, E. J. Willke. *Miami*—Charles Baker, John Beachler, G. J. Hance, E. R. Hiatt, B. M. Hogle, E. R. Irvin, Foster D. Kiser, L. N. Lindenberger, Kenneth F. Lowry, Maurice I. Miller, E. T. Pearson, H. R. Pearson, C. F. Puterbaugh, E. G. Puterbaugh, J. J. Shinn, W. W. Trostel, G. A. Woodhouse, E. A. Yates, Ralph D. Yates. *Monroe*—H. P. Gillespie, W. P. Johnson.

Montgomery—Elmer R. Arn, Sterling H. Ashmun, Roy S. Binkley, E. E. Bohlender, A. T. Bowers, L. G. Bowers, A. B. Brower, Wm. B. Bryant, Herbert L. Brumbaugh, C. E. Burgett, A. W. Carley, Homer D. Cassell, W. C. Clark, Abe Cline, D. B. Conklin, M. E. Coy, L. R. Courtright, T. H. Dickenson, H. V. Dutrow, Eleanora S. Everhard, Gertrude Felker, E. C. Fischbein, J. D. Fouts, Geo. D. Gohn, M. R. Haley.

H. C. Hanning, H. B. Harris, Jerome Hartman, W. Richard Hochwalt, J. K. Hoerner, H. F. Hilty, E. M. Huston, J. W. Irwin, Mildred E. Jeffrey, P. H. Kilbourne, Albert F. Kuhl, C. C. McLean, T. E. Newell, H. H. Pansing, A. O. Peters, Leo Schram A. F. Shepherd, Walter M. Simpson, Clement D. Smith, J. D. Smith, Webster S. Smith, Henry Snow, J. D. Spaid, W. B. Taggart.

Morgan—Lee Humphrey, C. E. Northrup, E. Galen Rex, A. W. Whitacre. *Morrow*—T. Caris, F. M. Hartsook, R. L. Pierce, E. C. Sherman, Frank H. Sweeney. *Muskingum*—R. B. Bainter, Edmund

R. Brush, D. G. Caudy, S. P. Carter, W. L. Cruise, O. I. Dusthimer, M. E. Fulk, H. R. Geyer, A. H. Gorrell, Beatrice T. Hagen, Lester Lasky, M. A. Loebell, Robert S. Martin, J. E. McCormick, W. A. Melick, A. C. Omerod, Sterling W. Obenour, G. B. Trout, John Philson, C. F. Sisk.

Perry—Edgar D. Allen, R. D. Book, F. J. Crosbie, O. J. Letherman, C. B. McDougal, W. D. Porterfield, R. W. Miller, Stanley Runk. *Pickaway*—D. V. Courtright, G. R. Gardner, R. S. Hosler, H. D. Jackson, Glen D. Sheets. *Pike*—R. M. Andre, W. L. McCaleb, I. P. Seiler. *Portage*—Iolas M. Huffman, E. H. Knowlton, B. H. Nichols. *Preble*—R. H. Jones, James I. Nisbet, C. M. Treffinger. *Putnam*—L. M. Piatt, B. E. Watterson.

Richland—Leopold Adams, Charles G. Brown, W. H. Buker, L. H. Gaston, John S. Hattery, L. C. Nigh, O. H. Schettler, J. L. Stevens, H. C. Winbigler. *Ross*—Walter C. Breth, H. R. Brown, Geo. W. Cooper, Theo. Cutright, John C. Franklin, L. T. Franklin, H. E. Harman, E. Hemmeger, Loy E. Hoyt, O. L. Iden, A. E. Merkle, Geo. S. Mytinger, David A. Perrin, E. C. Robbins, M. D. Scholl, Louis H. Senteff, W. B. Smith, L. M. Tinker, Orin R. Yost.

Sandusky—W. H. Booth, J. L. Curtin, Chester G. Egger, C. L. Fox, F. M. Kent. *Scioto*—Dow Allard, T. C. Crawford, R. P. Elder, C. L. Ferguson, Clyde M. Fitch, Jackson Herbert, A. P. Hunt, J. D. Jordan, T. G. McCormick, T. H. McCann, Gilbert Micklethwaite, H. H. Morris, H. C. O'Roark, W. A. Quinn, Harry F. Rapp. Joseph S. Rardin, R. H. Ruhmkorff, Wm. E. Scaggs, Oral D. Tatje, A. L. Test, Hubert Thurman.

Seneca—R. R. Hendershott, R. R. Kerchner, Edmund F. Ley, V. L. Magers, Burton A. Miller, T. T. Rosendale, Geo. W. Willard. *Shelby*—H. C. Clayton, A. R. Edwards, K. A. Hawver, A. W. Hobby, Cyril C. Hussey, V. W. LeMaster, Alfred B. Lippert, F. R. McVay, S. C. Yinger. *Stark*—S. B. Berkley, H. W. Beck, H. H. Bowman, J. R. Brandon, Roy H. Clunk, John P. DeWitt, Robert H. Firth, C. E. Fraunfelter, Harry W. Gauchet, Verl Z. Garster, Emerson Gillespie, Paul E. Gilmor, H. J. Giles, H. P. Hart, J. D. Holston, A. R. Olmstead, C. A. Portz, W. R. Portz, R. L. Rutledge, H. M. Schuffell, C. J. Schirack, Ray Schirack, J. E. Shorb, L. D. Stoner, Joseph D. Stires, John M. Van Dyke, F. S. Van Dyke, Geo. F. Zinninger, Pauline Zinninger, H. A. Zinninger.

Summit—E. C. Banker, James G. Blower, F. C. Bissell, L. E. Brown, H. Irving Cozad, Harry S. Davidson, P. A. Davis, E. B. Dyson, Edson A. Freeman, W. R. Henderson, John C. Hewgill, Glenn H. Heller, D. C. Keller, Charles E. Held, Walter A. Hoyt, Clyde Leeper, D. B. Lowe, G. A. Lucas, R. H. Markwith, Samuel E. McMaster, J. C. McClelland, M. M. Miller, John E. Monnig, Carl C. Nohe, R. G. Pearce, William A. Parks, F. C. Potter, Charles C. Pinkerton, Fred M. Rankin, Fowler B. Roberts, George R. Seikel, Carl R. Steinke, Fannie R. Stees, Ralph B. Tate, R. L. Thaw, Joseph M. Ulrich, Edw. L. Voke, J. N. Weller, J. P. Weis, C. F. Wharton.

Trumbull—J. H. Caldwell, W. D. Cunningham, R. D. Herlinger, Henry V. Omerod. *Tuscarawas*—Joseph Blickensderfer, F. A. Bower, Jay W. Calhoon, H. A. Coleman, W. W. H. Curtiss, R. J. Foster, G. A. Henry, Roy D. Hildebrand, George B. Kistler, William C. Roche, George L. Sackett, E. B. Shanley, J. M. Smith. *Union*—S. J. Bown, John Dean Boylan, J. L. Boylan, Fred C. Callaway, J. L. Davis, E. S. Holmes, P. D. Longbrake, Angus MacIvor, R. H. Martin, C. D. Mills, H. G. Southard, James M. Snider, F. M. Wurtzbaugh.

Van Wert—C. G. Church, B. L. Good, Roland H. Good, James R. Jarvis, Charles R. Keyser, J. B. Sampsell. *Vinton*—A. A. Boal, H. D. Chamberlain, H. S. James. *Warren*—Henry M. Brown, N. A. Hamilton, R. D. Herlinger, Leonard Mounts.

Washington—S. A. Cunningham, W. E. Radcliff, R. W. Riggs, W. W. Sauer, Jack F. Smyth, J. F. Weber. *Wayne*—Lyman A. Adair, Harold G. Beeson, John B. Beeson, O. G. Grady, R. C. Paul, W. G. Rhoten, Alonzo B. Smith. *Williams*—H. W. Wertz. *Wood*—H. J. Powell, Dan B. Spitler, F. L. Sterling, John J. Stitt. *Wyandot*—J. Craig Bowman, R. L. Garster, B. A. Maloney, F. M. Smith.

DR. J. J. MAREK, CLEVELAND, IS CROWNED KING OF OHIO STATE MEDICAL GOLFERS

The Fourteenth Annual Golf Tournament of The Ohio State Medical Golfers' Association was held at the Columbus Country Club on Wednesday, October 3, 1934. It was an ideal day for golf and the perfect weather added just the necessary zest to make the tournament one of the most delightful and successful ever held. The players chased the dew off the fairways and greens early in the morning and the last foursome came into the 18th hole (or should we say—the 19th hole) long after sundown, sinking final putts by candlelight. The beautiful course, with its rolling fairways, tricky holes and velvet greens, drew a field of 107 golfers away from their professional cares and worries for a day of fun. And it was a weary but happy crowd that closed the tournament with the customary evening banquet and distribution of prizes.

Dr. J. J. Marek of Cleveland is the new champion of the Ohio medical golfers. He played the morning round with a card of 79 and came back with a score of 78 strokes for the second 18 holes in the afternoon to make a total of 157 strokes for the 36 holes of medal play. Dr. Marek shot perfect golf to win the much coveted Championship Trophy and dethroned Dr. R. P. "Dick" Bell, also of Cleveland, who captured the title at Akron last year.

Dr. C. A. Hyer of Columbus was runner-up with a score of 160, while third low gross was won by Dr. L. M. Otis, Celina, with a score of 161 for the 36 holes of play. Dr. Otis held the Championship

Trophy in 1932 and offered stiff competition in the match.

The Ohio State Medical Journal Junior Trophy (a new trophy placed into competition for physicians 35 years of age and under, with three wins necessary for permanent possession) was won by Dr. A. K. Howell of Springfield with a gross score of 165 strokes. Second place in this event was won by Dr. E. R. Marker of Toledo with a card of 175, and third prize was awarded to Dr. C. V. Wolfe, Columbus, with a score of 181 for the 36 holes of play.

The State Auto Mutual Insurance Company Trophy (a second new trophy placed into competition for Low Gross—First 18 Holes of play for players between the ages of 36 and 45 inclusive) was won by Dr. F. J. Gallagher of Cleveland, with a score of 82. Second prize in this event was won by Dr. J. H. Rinehart of Springfield, and third prize was awarded to Dr. W. E. Masters of Columbus.

The Buckeye Union Casualty Trophy (open to players between the ages of 46 and 55 inclusive, awarded for Low Gross—First 18 Holes of play) was won by Dr. E. D. Saunders of Lakewood with a score of 79. Dr. E. C. Yingling, Lima, took second prize in this event, while third place was taken by Dr. J. D. Fouts of Dayton.

The Grand-dads Trophy, open to players over 55 years of age and awarded for Low Gross—First 18 Holes, was won by Dr. H. M. Schuffell of Canton. Second prize went to Dr. W. D. Inglis, Columbus, and third prize to Dr. W. C. Davis, also of Columbus.

The President's Trophy (a beautiful silver pitcher presented by Dr. F. C. Haney of Columbus) awarded for Low Net—First 18 Holes, 18 handicap or under, was won by Dr. H. C. Ashton of Basil with a score of 65.

The Golfers' Association Handicap Trophy, awarded for the Best 18 Holes Low Net with three wins necessary for permanent possession, was won by Dr. W. C. Scheidt of Celina. Dr. David Thomas, Lorain, took second prize and third prize was won by Dr. A. H. Reed of Cleveland.

Dr. F. W. Davis, Columbus, a courageous tenderfoot golfer, won a set of matched irons awarded for the High Gross score—18 Holes of play. His card tallied 122 strokes. Other prizes in this event were won by Dr. F. W. Gosnell, also of Columbus, and Dr. G. R. Gardner of Ashville.

Dr. W. R. Riddell, Jackson, won a beautiful wrist watch for Low Net score—First 18 Holes. Other prizes in this event were awarded to Dr. H. F. Fulton, Columbus, Dr. G. Micklethwaite, Portsmouth, Dr. V. L. Magers, Tiffin, Dr. J. B. Sampsell, Van Wert, Dr. J. P. DeWitt, Canton, Dr. J. E. Linden, Cleveland, Dr. J. P. Farson, Columbus, Dr. S. B. Berkley, No. Canton, and Dr. W. W. Sauer, Marietta.

Dr. Chas. Lukens. the veteran golfer from Toledo, won the Neil House Trophy awarded for Low Net—Second 18 Holes. Other winners in this event were Dr. L. M. Lisle, Columbus, Dr. R. R. Richison, Springfield, Dr. F. W. Thomas, Columbus, Dr. J. F. Wright, Toledo, Dr. M. R. Haley, Dayton and Dr. W. S. Henderson, Akron.

The Cleveland Delegation again won the Dr. John T. Murphy Trophy awarded for the 5 man team from any city with the aggregate low gross score for the 36 holes of play.

In addition to the above events many prizes were awarded to the players for par holes, birdies, eagles, least putts, most strokes any hole, and deuces on Holes 7 and 13.

Officers for the year 1935 are as follows: President, Dr. Louis Feid, Cincinnati; First Vice-President, Dr. M. R. Haley, Dayton; Second Vice-President, Dr. E. R. Marker, Toledo; Third Vice-President, Dr. F. W. Watson, Columbus; Fourth Vice-President, Dr. J. J. Marek, Cleveland; Fifth Vice-President, Dr. O. P. Tatman, Chillicothe; and Secretary-Treasurer, Dr. John B. Morgan, Cleveland.

The Columbus tournament was one of the most successful in the history of the organization. Many new members were added to the roster, the arrangements and details of the tournament were well cared for, the array of valuable prizes seemed endless, the evening banquet was a gourmet's delight, and the entertainment and hospitality shown the players was nothing less than perfect. An endless amount of hard work was required to make the tournament so successful and all who participated were loud in the praises and appreciation of the splendid job done by Dr. F. C. Haney, Columbus, retiring president of the Golfers' Association; Dr. C. A. Hyer, chairman of the Columbus committee on arrangements and his committeemen, Dr. Frank Watson, Dr. John Thomas, Dr. Robert Nosker, and Dr. William Drake; Dr. John B. Morgan, Cleveland, veteran secretary-treasurer of the association, and Henry Gerber, executive secretary of the Toledo Academy of Medicine, who served as general aide to and handy-man for the tournament committee.

Follow are the gross scores and handicaps of the players who participated:

Name	First Nine	Second Nine	Handi-Cap
Riddell, W. R., Jackson	43	41	16
	40	45,	
Schuffell, H. M., Canton	43	44	20
	48	46	
Stoner, L. D., Canton	50	53	24
	54	54	
Otis, L. M., Celina	42	41	9
	39	39	
Scheidt, W. C., Celina	47	44	20
	39	42	
Ruch, R. O., Lima	44	46	13
	42	49	
Micklethwaite, G., Portsmouth	49	47	25
	45	51	
Lewis, J. S., Youngstown	46	47	10
	45	45	
Carley, A. W., Dayton	44	49	19
	46	51	
Haley, M. R., Dayton	45	47	15
	46	43	

Name	First Nine	Second Nine	Handi-Cap
Fouts, J. D., Dayton	41	42	5
	40	42	
Hilty, H. F., Dayton	50	51	15
	51	47	
Bell, R. P., Cleveland	43	41	8
	43	40	
Morgan, J. B., Cleveland	49	52	19
	50	51	
Dwyer, W. E., Cleveland	48	47	16
	44	48	
Berkley, S. B., North Canton	40	43	10
	42	44	
Fletcher, T. R., Columbus	49	52	25
Magers, V. L., Tiffin	46	51	25
Dorr, H. H., Columbus	50	51	25
McConagha, A. B., Columbus	52	60	25
Green, F. M., Columbus	44	45	8
	41	45	
Anderson, F. C., Mt. Vernon	48	48	15
	45	50	
Blair, H. W., Mt. Vernon	45	46	15
	44		
Postle, H. H., Newark	52	49	25
	49		
Sapp, G. W., Newark	54	47	20
	50		
Hullinger, C. W., Springfield	46	49	15
	56	53	
Richison, R. R., Springfield	41	48	12
	42	42	
DeWitt, J. P., Canton	45	49	22
	45	50	
Gillespie, Emerson, Canton	41	46	11
	44	42	
Haney, F. C., Columbus	45	47	16
	48	47	
Marker, E. R., Toledo	43	45	11
	43	44	
Sauer, W. W., Marietta	44	44	15
	45	47	
Linden, J. E., Cleveland	49	48	25
Rinehart, J. H., Springfield	40	42	11
	48	44	
Howell, A. K., Springfield	40	43	9
	40	42	
Sprague, J. R., Athens	49	54	15
	49	53	
Halloran, F. A., Springfield	54	45	15
	46	49	
Mauger, R. C., Newark	50	47	18
	48	48	
Wynkoop, R. B., Ashtabula	49	49	18
	57	57	
Gallagher, F. J., Cleveland	37	45	10
	47	45	
Secrest, H. E., Columbus	48	48	14
	47	49	
Seibert, O. J., Cincinnati	48	51	13
	47	42	
Wiseley, A. N., Lima	52	51	18
	54	56	
Yingling, E. C., Lima	41	41	12
	44	42	
Price, C. A., Cincinnati	52	46	15
	47	51	
Hyer, C. A., Columbus	38	40	8
	38	44	
Thomas, David, Lorain	43	45	18
Watson, F. W., Columbus	42	44	7
	46	47	
Gardner, G. R., Ashville	53	64	25
	57	58	
Foster, R. J., New Philadelphia	50	52	18
	53	60	
Sackett, G. L., New Philadelphia	55	50	20
	49	57	
Sanders, C. N., Millfield	48	50	17
	51	54	
Henderson, W. S., Akron	48	49	20
	47	48	
McClelland, J. C., Akron	51	52	20
	47	56	
Hewgill, J. C., Akron	54	58	22
	47	58	
Nessley, G. B., Columbus	59	55	25
Drake, W. F., Columbus	50	46	21
Heller, G. H., Akron	64	50	25
Smith, Robt. G., Columbus	55	51	25
Wise, R. C., Mansfield	48	47	20
	45		
Findley, S. E., Mansfield	48	49	18
	49		
Weller, J. N., Akron	45	53	22
Thomas, F. W., Columbus	45	51	18
	45	45	
Miller, M. D., Columbus	51	51	25
Tatman, O. P., Chillicothe	50	43	12
Merkle, A. E., Chillicothe	52	55	25
Holmes, R. W., Chillicothe	52	51	25
Lewis, G. H., Lakewood	49	58	25
Farson, J. P., Columbus	43	48	18
	48	52	
Davis, W. C., Columbus	44	45	15
	47	48	
Millhon, M. E., Columbus	49	52	19
	51	56	
Davis, F. W., Columbus	61	61	25
	59	61	
Gosnell, F. W., Columbus	54	67	25
	58	60	
Callaway, F. C., Marysville	44	50	18
	49	51	
Masters, W. E., Columbus	44	38	11
	46	49	
Sampsell, J. B., Van Wert	44	46	18
	42	49	
Nosker, R. W., Columbus	46	46	13
	47	43	
Lisle, L. M., Columbus	49	48	19
	44	46	
Reed, A. H., Cleveland	49	50	18
	46	45	
Marek, J. J., Cleveland	37	42	5
	39	39	
Smith, A. C., Wooster	46	45	13
	46	45	
Lukens, Chas., Toledo	48	49	18
	43	45	
Wright, J. F., Toledo	50	50	25
	50	49	
Secrest, R. J., Columbus	49	47	20
	50	52	
Mark, Louis, Columbus	40	49	13
	43	47	
Buell, A. K., Columbus	43	44	10
	46	41	
Ashton, H. C., Basil	41	42	18
	44	41	
Wolfe, C. V., Columbus	42	47	15
	48	44	
Frederick, C. H., Lorain	44	50	15
	45	51	
Saunders, E. D., Lakewood	37	42	7
Nelson, L. D., The Plains, O.	54	60	22
Fulton, H. F., Columbus	46	47	25
Ross, T. F., Columbus	56	55	25
Hall, F. E., Columbus	56	54	25
Myers, R. D., Columbus	55	48	25
Christie, C. D., Cleveland	51	51	24
Larrick, C. M., Columbus	44		14
Bolton, J. P., Columbus	44		14
Grattidge, C. T., Laurelville	45		18
Thomas, John M., Columbus	51		21
Crotti, Andre, Columbus	50		25
Inglis, W. D., Columbus	44	44	18

—OSMJ—

A board of county commissioners may, with the approval of the State Relief Commission, use a part of the allowance which they make to a family out of local poor relief funds to pay the expenses of a child of such family at a summer health camp for the purpose of arresting the development of tuberculosis in such child, even though this may necessitate a slight increase in the total allowance ordinarily allowed such a family, according to an opinion handed down recently by Attorney General John W. Bricker.

—OSMJ—

The Radiological Society of North America will hold its 1934 annual meeting at the Hotel Peabody, Memphis, Tennessee, December 3-7. Information may be obtained concerning the meeting from Dr. Donald S. Childs, 607 Medical Arts Building, Syracuse, New York. The counselors of the society from Ohio are Dr. B. H. Nichols, Cleveland, and Dr. E. R. Bader, Cincinnati.

—OSMJ—

—Dr. F. R. Dew, former Belmont County health commissioner, has been appointed health commissioner of Lorain County, succeeding Dr. H. R. O'Brien, resigned.

PROSPECTIVE CHANGES IN COUNTY GOVERNMENT, LOCAL HEALTH ADMINISTRATION AND MEDICAL CARE OF THE NEEDY — STATUTORY PROVISIONS DISCUSSED

Numerous proposals providing for reorganization, consolidation and modification of local governmental functions in Ohio are under consideration at the present time and undoubtedly a number will be introduced at the regular session of the 91st General Assembly which will convene in Columbus in January, 1935.

Members of the medical profession should keep fully and accurately informed on developments to revamp local governmental set-ups and functions, and be prepared to take a direct and active part in conferences and negotiations on these plans and suggestions not only because, as citizens and taxpayers, physicians are vitally concerned in the operation and form of local governmental units but because undoubtedly many such proposals will provide for:

1. Changes in present systems of local public health administration;
2. Changes in the present local systems of providing relief for the poor or possibly the establishment of an entirely new plan of local poor relief administration, including medical care to the needy.

During the past few years, considerable sentiment has developed in Ohio for extensive changes in and simplification of the machinery of local governments. Charges have been made that under present systems of county and municipal government the costs of government have become excessive, and administration inefficient in relation to present-day needs, and that there is much duplication and over-lapping of the functions of various public offices.

Considerable momentum was given to organized movements for a complete overhauling of local governmental machinery by the adoption at the November, 1933, election of an amendment to the Constitution of Ohio, known as the "County Home Rule Government Proposal".

Briefly, this amendment adopted by the electorate of the state by a substantial margin, repealed all of Article 10 of the Constitution relating to county and township governments and Section 16 of Article 4 relating to the election and functions of the clerk of courts and incorporated in the Constitution a new Article 10 consisting of four sections.

This new Article 10 requires the Ohio General Assembly to provide by law for the organization and government of counties, and permits alternative forms optional with the voters of any county; authorizes municipalities and townships to transfer powers to the county with its consent, and to withdraw such powers, all subject to the initiative and referendum; bring together into one new section the effective provisions of old Article 10 applying to townships, with a slight increase in local powers; authorizes counties to frame and adopt, or amend, charters establishing the form of their government; permits the adoption of a charter giving the county concurrent or exclusive municipal powers, or making the county a consolidated municipality, with local taxing and administrative districts, under safeguards for the protection of local minorities; provides for the submission of the question whether a county charter commission should be chosen, and for the election of fifteen electors as such commission, by popular vote, with not more than seven from any one municipality; provides for the framing of a charter by such commission and for the submission of amendments by initiative; provides that all elections except that for the charter commission shall be on the same date as general elections; provides for the distribution of copies of charters and amendments and for the effective date of charters and amendments and for conflicts between two or more amendments adopted at the same time, and provides that the constitutional amendment shall be self-executing except as to transfer of powers of municipalities and townships to the county.

Under the provisions of the amendment, the General Assembly can authorize the choice of certain county officials by appointment rather than election. It has authority to consolidate county offices and centralize services now being performed by several different departments, offices, etc. It has the power to enact optional plans of county government, each plan designed to fit the requirements of counties of various sizes and character.

At the forthcoming general election on November 6, the voters of a considerable number of counties will be called upon to vote on the question of a county charter commission and to elect the members of such commission. Under the provisions of the constitutional amendment, the commission elected will proceed to frame a new charter for their respective counties, modifying the present system of county government or establishing an entirely new system, for submission to the voters at the following general election. Such new charter, of course, would be subject to any gen-

eral laws on the organization and government of counties enacted by the General Assembly.

During the past year, a Commission on County Government, appointed by Governor White, has been conducting an intensive study of the problems of county reorganization, preparatory to drafting a series of optional plans of county government for submission to the Legislature. The Commission is composed of Charles P. Taft, 2nd., chairman, Paul Belden, Harold Burton, Charles E. Chittenden, Carl Friebolin, Robert Gorman, Robert Guinther, Francis W. Kennedy, Walter F. Kirk, Murray Lincoln, Mark Selby, Mrs. N. M. Stanley, and R. C. Atkinson, secretary.

Numerous Changes in Local Public Health Administration Proposed

Obviously, most proposals for remodeling present county government systems or combining county and municipal governmental machinery within a county would directly affect public health administration.

Among proposals now under consideration are the following pertaining to public health administration:

1. Inclusion of public health administration under a county department of welfare to take over all county relief, welfare and health activities.

2. To establish a health department and welfare department entirely separate but assigning to each certain services and functions now being handled by independent commissions, boards and bureaus.

3. To facilitate the merger of county and city health departments into one department to serve the entire area.

4. To make the county health district a part of county government, with its head appointed by the county commissioners or county executive officers.

5. Abolishing boards of health and district advisory councils.

6. Include the public health budget in the general county budget and revise in numerous respects the financial set-up for health administration and methods of handling revenues for health administration together with other county offices and departments.

Since some changes in the present methods of local public health administration are quite likely to be made in counties where complete or partial governmental reorganization will be attempted, it is important that the medical profession carefully follow all developments and demand that the profession be consulted on matters involving changes in public health set-ups. The medical profession is vitally concerned in the maintenance of public health administration on a sound, effective basis. Naturally, it should favor and support suggested changes that will increase efficiency in public health work, put public health administration on a sound financial basis, and provide greater safeguards for the public. On the other hand, physicians would be expected to use their influence against proposed changes in local public health machinery or functions which would submerge public health administration, scatter responsibility, and impair or destroy the efficiency of local health departments.

Complicated Problems Anticipated In Connection with Poor Relief Laws

With the increased problem of direct relief to the needy and unemployed, even more complicated will be numerous questions arising from anticipated proposals seeking to establish new systems of providing poor relief as a part of the responsibilities of local governmental units or radical revision of present statutes governing local poor relief, including medical, nursing and hospital care for indigents.

Undoubtedly some of the proposals to be submitted under the provisions of the "County Home Rule Amendment" will provide for extensive changes in present methods of handling community poor relief problems.

Moreover, it is likely that the State Legislature will be requested to deal directly with the matter of revising the poor laws and not to delay amending them in anticipation that the different counties will establish better methods of poor relief under the reorganization provisions of the home rule amendment.

In addition, acute questions pertaining to financing poor relief activities which are now supported by local revenues are anticipated, further complicating the situation. For example, at the forthcoming general election there will be a vote on a constitutional amendment limiting the state gasoline tax to 3 cents and restricting the use of revenues derived from the gasoline tax and from the sale of vehicle license tags to the building and maintenance of highways. If adopted, this amendment will prevent the diversion of gasoline tax money for poor relief and abolish what has for several years been one of the chief sources of many local subdivisions for poor relief funds. Moreover, it will prevent the reenactment or the operation of the temporary statute now in effect providing for the payment to hospitals for services rendered to indigents injured in motor vehicle accidents.

Hospitals Propose New Set-Up for Medical Services to The Indigent

Several proposals providing extensive changes in the poor relief laws have been formulated and may be submitted to the State Legislature when it convenes next January. At present the Ohio Hospital Association has under consideration a

legislative proposal revising and supplementing the existing statutes pertaining to the furnishing of medical and hospital care to indigents.

Briefly, this proposed legislation would amend the poor laws to centralize the responsibility of providing medical, nursing and hospital care for the indigent with the county health commissioner or city health commissioner, as the case may be, or the officer in charge of public health service within a municipality. It leaves with the county commissioners, township trustees or municipal poor relief authorities, the authority to administer all other poor relief activities now under their respective jurisdictions—that is, any poor relief activities which do not come within the meaning of medical, nursing and hospital care.

Obviously, it is of vital importance that the medical profession realize the complexity of any attempt at this time to readjust the present system of poor relief in the various counties, townships and municipalities. The question is closely associated with the movement for reorganization of county government. Moreover, as long as the need for state and federal aid in caring for the poor exists, it is doubtful if this governmental function will, or can, be left primarily to those local agencies which have the authority under Ohio statutes to carry on relief activities. Nevertheless, the medical profession should be prepared to cooperate on negotiations on this question, to insure that the medical angles of poor relief are given proper consideration and adequate provision made for the compensation of physicians, hospitals, nurses, etc.

Old Relief Plans Unable to Meet Emergency in Most Communities

Even before the present emergency and the tremendous increase in the poor relief load, necessitating state and federal intervention and the inauguration of the present relief system under the State Relief Commission, there was widespread dissatisfaction with local methods of providing relief for the poor. Ohio's poor laws have been criticized as antiquated and the methods followed in most communities as inefficient and inadequate.

Although at present most relief activities throughout the state are carried on under the direct supervision of the State Relief Commission, through the various county relief directors, and are financed from federal-state funds, some political subdivisions are carrying on this function in compliance with Ohio poor relief statutes and with local funds.

Grants from the State Emergency Relief Fund and federal funds allotted to Ohio for poor relief activities are made by the State Relief Commission to political subdivisions upon the basis of supplementing local resources applicable to relief needs. When and where local funds are available for poor relief, and requests have not been made for state or federal aid, the administration of relief activities is left to the proper officials—township trustees, county commissioners, city relief officer or department, etc. In most communities, because of inadequate funds, federal-state aid has been necessary and poor relief work has been organized on a county-wide basis under a county relief administration. In others, former systems of caring for the poor prevail, with the activities being carried on by the different political subdivisions.

Methods of providing medical care for the poor have, together with other poor relief activities, been adjusted to meet present conditions. In most counties, medical service has become a part of the poor relief activities of the county relief administration which activities are financed largely from federal-state funds. Functions formerly carried on by local authorities have been taken over by the county relief director and medical relief throughout the county provided under the terms of Rules and Regulations No. 7, F.E.R.A. However, in a few localities, local officials still are providing medical care for the poor and financing it with local funds. In some instances this has proven satisfactory.

Lorain Plan of Providing Medical Care for Poor Locally Outlined

For example, in the City of Lorain medical services, including the services of a physician, medicines and hospitalization, are supplied the indigent under an agreement between the Department of Public Safety and the medical profession of the city. Local funds are used to carry on this service. The work is done under a fee schedule mutually agreeable and the free choice of physician is preserved. The responsibility of investigating cases and authorization of medical services subsequent to the initial visit of a physician is assumed by the Department of Public Safety. Where the patient does not have a family physician or no choice as to a physician, the case is referred by the Safety Director to a physician whose name appears on a panel submitted to him by representatives of the medical profession. In handling such case, the names of physicians are rotated.

The way the medical relief situation is handled in Lorain is cited to show that through conferences and agreements between the medical profession and the proper officials, effective and satisfactory medical services to the poor can be maintained locally even under present poor relief statutes and exclusive of the county-wide set-up, and where federal-state funds for emergency relief are not used.

In some cities, attempts have been made to provide medical care through a system of employing physicians on a full- or part-time basis. This plan has not met with much success because in most

instances there has been a lack of adequate funds to provide a sufficient number of physicians to meet the unprecedented heavy relief load or to pay the employed physicians an amount commensurate with the services rendered.

Ohio Laws Pertaining to Medical Care of Indigents Summarized

In the March, 1932, issue of *The Journal*, pages 203-207, there was published an article summarizing in detail the Ohio statutes on poor relief as they apply to medical and hospital services, etc. For the purpose of emphasis the principal provisions of these sections of the General Code of Ohio will be analyzed in succeeding paragraphs.

Sections 3476, 3477, 3478 and 3479 of the General Code govern the eligibility of a person to poor relief and determine the question of "legal settlement". In brief, these sections specify that the township trustees are responsible for providing poor relief for indigents who have established a legal residence in the county and a legal residence in the township; the board of health of a city or board of health having jurisdiction in the municipality for indigents who have established a legal residence in the county and a legal residence in the city; and the county commissioners for indigents who have not established legal residence in any township or city within the county, those permanently disabled or have become paupers, and those whose peculiar condition is such that they cannot be satisfactorily cared for except in a county home or under county control.

"Legal residence" as defined by the foregoing sections means in the case of the county one year's continuous residence without relief of any kind and in the case of the township or city, three months' continuous residence on a self-supporting basis.

Townships and cities have the choice of two methods of furnishing medical care to the indigent sick. Under the provisions of *Section 3490*, the township trustees or the proper municipal officials may contract with one or more physicians to furnish medical care to eligible indigents. Under the provisions of *Section 3480*, the township trustees or municipal officials are liable for medical services rendered eligible indigents by the physician of their choice. However, it is mandatory that a physician attending a person entitled to relief shall notify the township or municipal authorities within three days after the first visit in order to obtain compensation for his services. The township or municipal authorities may order at any time the discontinuance of the physician's services. Moreover, they have the authority to pay whatever fee they may determine to be "just and reasonable." Many difficulties have arisen over the question of fees for such services but in some places satisfactory agreements have been worked out through conferences and proper contacts by the medical profession with local public officials.

Section 2546 authorizes the county to contract with one or more physicians to furnish medical care to the inmates of the county home but prohibits the county from furnishing medical care to persons in their homes unless they have not established legal residence in the county and the township or city in which they reside. In such cases the county is obliged to furnish necessary medical care and to compensate physicians rendering such service.

Sections 3481 to Sections 3482-2, inclusive, and *Section 4438* provide the mechanics whereby counties, townships and cities may be reimbursed from other counties, townships and cities for medical services furnished indigents having legal residence elsewhere than the place where they were residing at the time the medical service was rendered.

All physicians should familiarize themselves with the provisions of the various poor relief laws. Moreover, representatives of the county medical societies should contact the various local relief officials and work out with them suitable and satisfactory methods. It should be remembered that where the county-wide plan of poor relief has *not* been adopted, relief work, including medical service, is a responsibility of the county, townships, or municipalities, as the case may be, in conformity with the statutory requirements on poor relief. As long as the system under the State Relief Commission is in effect, the state poor relief laws will be inoperative in most communities —those who are using federal-state funds. However, they are applicable to counties carrying on relief work with local funds.

— OSMJ —

Medical Exams Set for Dec. 4, 5 and 6

At its regular meeting October 2 in Columbus, the State Medical Board set the December examinations for licenses to practice medicine and surgery and the limited branches of medicine in Ohio for December 4, 5 and 6 in Columbus. The certificate to practice osteopathy of Charles B. Robertson, Cincinnati, was revoked.

— OSMJ —

Cincinnati—Dr. Frank D. Phinney is in Newfoundland conducting surgical clinics for the Grenfell Foundation, a work he has been doing during the summer months for the past nine years.

— OSMJ —

Steubenville—Dr. John L. Quinn, formerly of Worcester, Mass., has opened offices here.

— OSMJ —

Irondale—Offices have been opened here by Dr. W. S. Banfield, formerly of Wellsville.

Study Outline No. 5

COLLES' FRACTURE

By RUSSELL H. BIRGE, M.D.
CLEVELAND, OHIO

THIS is the fifth of a series of "Study Outlines" being published in *The Journal* for use by the Program Committees of the component county societies and academies of medicine, if they desire, in formulating programs and stimulating participation by all members in scientific discussions. A detailed explanation of the plan was published in the August, 1934, issue of *The Journal* together with Study Outlines No. 1 and No. 2. Study Outline No. 3 appeared in the September, 1934, issue, and Study Outline No. 4 in the October, 1934, issue. Additional outlines will appear in *The Journal* each month.

OUTLINE FOR STUDY

1. Mechanism:
2. Varieties:
3. Symptoms:
   - A. Silverfork deformity.
   - B. Dorsal and radial displacement of distal fragment.
   - C. Fracture of the ulnar styloid and ventral displacement of the head of the ulna.
   - D. Displacement of radial styloid upward.
   - E. Alteration of the normal line of articulation of the distal fragment with wrist joint.
4. Differential Diagnosis:
   - A. Simple sprain.
   - B. Fractured scaphoid.
   - C. Dislocation of semilunare.
   - D. Reversed Colles.
5. Reasons for Serious Disability if not Properly Reduced:
   - A. Alteration of joint line and dorsal displacement seriously interfere with flexion and extension.
   - B. Pronation and supination.
   - C. Radial displacement with adduction and abduction.
6. Treatment:
   - A. Local or general anesthetic.
   - B. Thorough breaking up of impaction so that distal fragment can be moved freely.
   - C. Restoration of normal anatomical relations.
   - D. Fixation in moulded plaster splints.
7. Care after Reduction:
   Importance of active motion of finger and thumb during period of immobilization followed by physiotherapy.
8. Time Required for Union.
9. When Should Splint be Removed.

SUGGESTION FOR PAPER

The Diagnosis and Treatment of Colles' Fracture.

Reference

Magnuson, Paul B.—"Fractures"—Fig. 120 and 123.
J. B. Lippincott Co., 1933.

— OSMJ —

Ohio Leads the Nation in "Sight-Saving Class" Work

The State of Ohio continues its leadership of two decades in the work of "sight-saving classes" for the education of school children with seriously defective vision, it has been announced by Dr. Lewis H. Carris, Managing Director of the National Society for the Prevention of Blindness, New York City. The movement which was started in 1913—when a special class for partially sighted children was formed in Cleveland—has been extended to 125 cities throughout the United States. More than 6,000 children now attend such classes.

In a message of congratulations—on the 20th anniversary of the sight-saving class movement in America—forwarded to Governor George White and to Dr. B. O. Skinner, head of the Department of Education in Ohio, Dr. Carris pointed out that the number of sight-saving classes has increased steadily from the two which existed in December, 1913—one in Cleveland and another in Boston—until the number now totals 430. Of these, 66 are maintained in the public schools of Ohio. Only New York, with its 111 classes, has a larger number, but Ohio has consistently held first place for 20 years, through having the largest number of classes in proportion to its school population.

— OSMJ —

Zanesville—Dr. Margaret O'Neal, a native of Zanesville, has opened offices for specializing in diseases of infants and children. Dr. O'Neal has been engaged in research work in Cleveland for the past few years.

Medical Institute In Toledo Scheduled For Friday, November 2nd

First annual presentation of the Medical Institute of the University of Toledo is scheduled for Friday, November 2, in Doermann Auditorium at the University.

The institute is under the direction of Philip C. Nash, president of the University, and Dr. Fred M. Douglass, Dr. John T. Murphy and Dr. Barney J. Hein, alumni of the former Toledo Medical College.

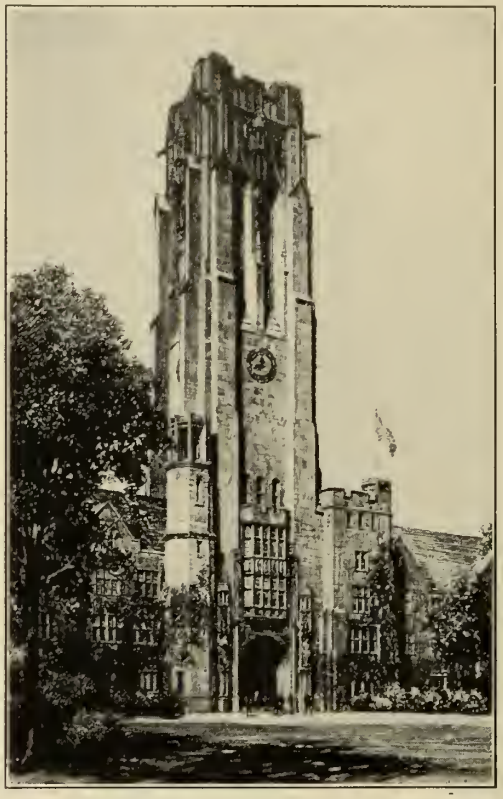
The program for this inaugural Post-graduate Day is "The Diagnosis and Treatment of Pulmonary Tuberculosis—Medical and Surgical Aspects". The speakers are Dr. Lawrason Brown of Saranac Lake, New York, who will give the medical presentation, and Dr. Evarts A. Graham of St. Louis, Mo., who will discuss the surgical phase of the subject. Both men have national recognition for their work in tuberculosis. Dr. Brown is a member of the American College of Physicians, the American Clinical and Climatological Association and the American Association for Thoracic Surgery. Dr. Graham is Bixby Professor of Surgery at Washington University School of Medicine and a member of the American Surgical Association, the American College of Surgeons, the Society of Clinical Surgery and the American Association for Thoracic Surgery.

A cordial invitation to attend the First Annual Post-graduate day of the Medical Institute of the University of Toledo has been extended to every member of the medical profession. It is particularly hoped that physicians in Toledo, northwestern Ohio, eastern Indiana and southern Michigan will avail themselves of the opportunity to attend the meeting. A registration fee of $2.00 will be charged to cover the minor incidental expenses of the meeting, which fee will also include luncheon and dinner at the University. The program will begin at 10 o'clock in the morning. The morning session will be from 10:00 A. M. to 1:00 P. M.; luncheon hour from 1:00 to 2:00 P. M.; afternoon session from 2:00 to 5:00 P. M.; dinner hour from 6:00 to 8:00 P. M.; and the concluding evening lecture from 8:00 to 9:30 P. M. The time has been arranged so as to suit the easy convenience of all interested out-of-town physicians.

By special invitation, the Toledo Academy of Medicine will join with the Medical Institute for the closing evening lecture.

The idea of inaugurating an annual post-graduate medical assembly originated with Toledo alumni of the old Toledo Medical College. When the medical college was closed in 1914, the retiring board of trustees turned over a sum of money to the newly organized University of Toledo to be used solely for purposes of medical education, if and when such courses should be included in the university curriculum.

It was not until early in 1934 that the plan of using the income from this fund for an annual medical institute was presented. The idea met with the enthusiastic approval of the board of trustees of the university. The result will be the forthcoming institute which will become an annual affair.



TOLEDO UNIVERSITY TOWER

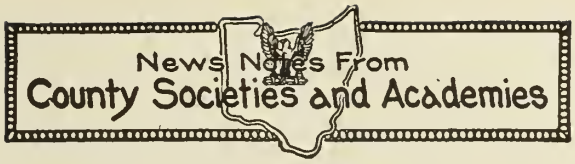
— OSMJ —

Change Made in Supplying State Laboratory Outfits

A new method of handling mailing outfits for specimens to be analyzed by the State Department of Health Laboratory has been announced by the State Department of Health.

On October 15, the laboratory abandoned its previous policy of supplying mailing containers to private physicians and instituted a plan of having such containers handled by city and county health departments from which physicians may obtain them.

Under the new plan individual orders for containers will not be filled by the laboratory and only outfits furnished by the laboratory through the local health departments will be accepted.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

September 24—General Session. Program: Annual address of the retiring president, Dr. Samuel Iglauer; installation of new officers, as follows: President, Dr. John A. Caldwell; secretary, Dr. H. J. Lavender; treasurer, Dr. Charles E. Hauser; trustees, Dr. Otto J. Seibert and Dr. E. O. Swartz; address of the incoming president, Dr. Caldwell; reports of committees by the following chairmen: Dr. Otto J. Seibert, Public Policy; Dr. Richard Austin, Dispensary Service; Dr. Carl A. Wilzbach, Advertising Committee and Committee on Preventive Medicine; Dr. Albert Bell, Milk Committee; Dr. Ralph Carothers, Medical Defense; Dr. Samuel Zielonka, Medical Economics. Dr. Caldwell announced the appointment of Dr. Parke G. Smith, Dr. H. B. Weiss, and Dr. M. M. Zinninger as members of the Program Committee for the ensuing year.

October 1—General Session. Program: "The Physician in Historical Retrospect", Dr. David A. Tucker; "The Diagnosis and Treatment of Posttraumatic Osteoporosis", Dr. Louis G. Hermann; discussion by Dr. John A. Caldwell and Dr. Ralph G. Carothers.

October 8—General Session. Program: "Total Removal of Thyroid", Dr. Herrman L. Blumgart, associate professor of medicine, Harvard University Medical School.

October 15—General Session. Program: "Symposium on Appendicitis", by the following: Dr. Floyd Allen, public health aspects; Dr. C. C. Fihe, medical aspects; Dr. Paul Merrill, hospital mortality; Dr. J. Louis Ransohoff, surgical aspects; discussion opened by Dr. Charles Souther.

October 22—General Session. Program: "The Diagnosis and Treatment of Pernicious Anemia", Dr. Murray L. Rich; discussions by Dr. H. B. Weiss and Dr. Charles E. Kiely; "The Rationale of the Diagnosis and Treatment of Sterility from the Gynecological Point of View", Dr. George Lyford; discussions by Dr. J. M. Pierce and Dr. J. R. Stark.

October 29—Joint meeting with Cincinnati Heart Council. Program: "Heart Pain of Organic Origin", Dr. Louis Hamann, associate professor of medicine, Johns Hopkins University Medical School; "Heart Pain of Functional Origin", Dr. Walter W. Hamburger, clinical professor of medicine, Rush Medical College, Chicago.

Adams County Medical Society met on October 17 at the Hotel Hester, Manchester. Following a business session and luncheon, the following program was presented: "Puerperal Infection", Dr. F. C. Leeds, Winchester; discussion by Dr. J. M. Brooke, Peebles; "Cancer of the Rectum and Colon", Dr. Wells Teachnor, Sr., Columbus; discussion by Dr. O. E. McHenry, Blue Creek; "Acute Poliomyelitis", Dr. A. R. Carrigan, Manchester; discussion by Dr. R. Y. Littleton, Stout. —Bulletin.

Clermont County Medical Society met at the home of Dr. Carl Minning, Williamsburg, on September 19. The guest speaker was Dr. H. H. McClellan, Dayton.—News Clipping.

Clinton County Medical Society was entertained at an outing at the camp of Dr. Frank Peelle north of Wilmington on September 11. The wives of the members and dentists of the county were guests. The guest speaker was Dr. R. H. Speckman, Cincinnati, who spoke on "Heart Disease".—News clipping.

Second District

Darke County Medical Society held a dinner meeting October 19 at the Christian Church, Greenville. The guest speaker was Dr. Jonathan Forman, Columbus, who spoke on "Allergy in General Practice".—W. D. Bishop, M.D., secretary.

Miami County Medical Society met October 12 at Memorial Hospital, Piqua. The principal speaker was Dr. Hugh Wellmaier, Piqua, whose subject was "Congenital Syphilitic Conditions in Children". Report on the Annual Meeting of the State Association was presented by Dr. Foster Kiser. Dinner was served following the program. —G. A. Woodhouse, M.D., secretary.

Montgomery County Medical Society opened its Fall meetings on September 28 with the following program: "Treatment of Common Infections of the Eye", Dr. A. M. Culler; "Treatment of Common Infections of the Skin", Dr. E. C. Loomis; "Treatment of Common Infections of the Genito-Urinary Tract", Dr. R. E. Tyvand; discussions by Dr. R. S. Binkley, Dr. T. C. Sheridan, and Dr. L. G. Kauffman, respectively.

On October 19, the society was addressed by Dr. Virgil S. Counseller of the Mayo Clinic, Rochester, Minn.—Bulletin.

Preble County Medical Society at a dinner session September 20 at Seven Mile Tavern, near

Eaton, was addressed by Dr. J. C. Walker, Dayton, on "Fractures of the Hip".—Bulletin.

Third District

Allen County—The Academy of Medicine of Lima and Allen County was addressed on September 18 by Dr. Norris W. Gillette, Toledo. Dr. Gillette spoke on "Abdominal Surgery in Children".—News Clipping.

Hardin County Medical Society in session September 20 at Kenton was addressed by Dr. H. H. McClellan, Dayton. Dinner was served following the program.—News Clipping.

Seneca County Medical Society was addressed by Dr. Walter G. Stern, Cleveland, at its annual dinner at Lake Mohawk on September 20.—News Clipping.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(A. P. Hancuff, M.D., Secretary)

October 5—General Session. Program: "The Relation of Cell Size to the Classification of Some Commonly Encountered Anemias", Dr. Robert H. Crawford, Indianapolis.

October 12—Section of Pathology, Experimental Medicine and Bacteriology. Program: "The Use of Cardiac Drugs", Dr. F. C. Clifford; "Coronary Disease", Dr. J. Lester Kobacker; "Myocardosis", Dr. N. W. Brown.

October 19—Surgical Section. Program: "Factors in the Treatment of Varicose Veins", Dr. J. H. Smith; discussant, Dr. F. P. Osgood; "The Injection Treatment of Hemorrhoids", Dr. L. J. Herold; discussant, Dr. W. W. Green.

October 26—Annual Joint Meeting of the Academy of Medicine and the Toledo Dental Society. Program: "Medical Testimony from the Point of View of a Trial Lawyer", Crary Davis, LL.B.; discussants, L. A. Miller, M.D., R. H. Vollmayer, D.D.S., and George R. Effler, LL.B.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

October 3—Obstetrical and Gynecological Section. Program: "Calcium in Obstetrics and Gynecology", Dr. Paul Spurney; "Carcinoma of the Cervix Complicated by Pregnancy with a Report of Two Cases", Dr. A. Strauss; "Abdominal Pregnancy", Dr. Theodore Miller and Dr. F. F. Jordan.

October 10—Clinical and Pathological Section. Program: "Hydronephrosis in a Child Due to Aberrant Artery", Dr. W. J. Engel; "A Case of Paroxysmal Hemoglobinuria", Dr. A. C. Ernstene; "Regional Illness", Dr. T. E. Jones; "A Case of Felty's Syndrome with Splenectomy", Dr. R. H. McDonald; "Subdural Hematoma", Dr. W. J. Gardner; "Osteomyelitis of the Frontal Bone", Dr. W. V. Mullin and Dr. W. L. Deeton; "The Treatment of the Neurological Lesions of Pernicious Anemia", Dr. R. L. Haden.

October 12—Joint Meeting of Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program: "The Electrocardiogram and the Phases of Cardiac Systole in Pellagra", Dr. H. S. Feil; "Bilirubin-Urobilin Ratio in Human Gall Bladder Bile", Dr. M. A. Blankenhorn; "The Pressure of Creatinine in Blood", Dr. J. M. Hayman, Jr., Dr. J. A. Bender and S. M. Johnston; "Vitamine A and the Common Cold", Dr. G. S. Shibley and Dr. T. D. Spies; "The Significance of the Dissociation of Bacillus Pertussis in Whooping Cough", Dr. G. S. Schibley and H. Hoelscher, M.A.; "Studies on Iron Excretion in Anemia", R. F. Hanzal, Ph.D., and Dr. J. A. Bender; "The Determination of Lead in Biological Material", R. F. Hanzal, Ph.D.

October 17—Pediatric Section. Clinic at Babies' and Children's Hospital.

Otcober 17—Industrial Medicine and Orthopedic Section. Program: "Unusual Type of Tuberculosis of the Spine", Dr. J. Carmody; "Preliminary Reports of Epiphyseal Fusion", Dr. W. H. McGaw; "Fasciotomy for Relief of Sciatic Pain", Dr. Clarence Heyman; "Observations on Treatment of Ununited Fractures", Dr. Maxwell Harbin.

Huron County Medical Society was addressed on September 19 by Dr. M. B. Cohen, Cleveland. The subject of Dr. Cohen's address was "Skin Diseases Associated with Allergy and Their Management".—News Clipping.

Medina County Medical Society held its annual outing on September 16 at Rice's Dam near Lodi. Among the guests were Dr. C. L. Cummer, Cleveland, president of the State Association; Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, and Dr. J. E. Tuckerman, Cleveland, chairman of the Committee on Medical Defense of the State Association.—News Clipping.

Sixth District

Ashland County Medical Society met October 12 at Samaritan Hospital, Ashland. Dr. H. H. McClellan, Dayton, was the guest speaker.

On September 12, the society held a picnic at Long Lake, with the wives of the members as guests.—M. J. Thomas, M.D., secretary.

Mahoning County Medical Society was addressed on October 23 by Dr. John Duff, member of the surgical staff, New York Hospital, on "Renal and Ureteral Calculus". At its meeting on November 20, the society will be addressed by Dr. Frank H. Lahey, Boston, on "Cancer of the Rectum and Colon".—Bulletin.

Summit County Medical Society in regular session October 2 at the Mayflower Hotel, Akron, was addressed by Dr. W. C. Danforth, Evanston,

Illinois, assistant professor of obstetrics and gynecology, Northwestern University, on "Occiput Posterior".—Bulletin.

Stark County Medical Society met on October 9 at the Canton Women's Club. The guest speaker was Dr. I. S. Ravdin, professor of surgical research, University of Pennsylvania, who spoke on "Acute Appendicitis".—Bulletin.

Seventh District

Tuscarawas County Medical Society met on October 11 at New Philadelphia to hear reports on the Annual Meeting of the State Association at Columbus.—Bulletin.

Eighth District

Fairfield County Medical Society at a luncheon meeting September 13 at Lancaster was addressed by Dr. J. W. Means, Columbus, on "Suppurative Appendicitis".—News Clipping.

Guernsey County Medical Society in session September 6 at the Berwick Hotel, Cambridge, was addressed by Dr. D. L. Cowden, county health commissioner, on "State Medicine".

On September 20, the society entertained the wives of the members at a "Ladies' Night" party. A chicken dinner was served, following which a program of entertainment and cards was presented.—O. R. Jones, M.D., correspondent.

Perry County Medical Society met September 17 at the Park Hotel, New Lexington. Dr. Thomas F. Ross, Columbus, addressed the society on "Some Phases of Obstetrics of Interest to the General Practitioner".—News Clipping.

Muskingum County—The Academy of Medicine of Muskingum County met in regular session October 2 at Bethesda Hospital, Zanesville. The program was presented by Dr. George C. Malley, who spoke on "Intra-Cranial Hemorrhage of the New Born", and Dr. Margaret O'Neil who read a paper on "Pyloric Stenosis in the New Born".

Ninth District

Scioto County—Regular meeting of the Hempstead Academy of Medicine was held on October 8 at Portsmouth. The academy was addressed by Dr. A. L. Test, Portsmouth, on "Eclampsia".—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

October 8—General Session. Program: "Hyperinsulinism—Treated by Resection of Pancreas", Dr. Robin C. Obetz, history and medical discussion; Dr. I. B. Harris, surgical considerations, and Dr. H. L. Reinhart, pathology; "Intraspinal Injection of Alcohol for Control of Intractable Pain", Dr. Frank E. Hamilton.

October 15—General Session. Program: "Century of Progress in Medicine", Dr. W. W. Bauer, director, Bureau of Health and Public Instruction, American Medical Association.

October 22—General Session. Program: "Papilloedema—Its Clinical Significance", Dr. Albert D. Frost; discussants, Dr. John Edwin Brown and Dr. W. C. Davis.

October 29—General Session. Program: "A Resume of the Treatment of Syphilis", Dr. John E. Rauschkolb, Jr., professor of dermatology, Western Reserve University.

Pickaway County Medical Society met September 7 at the Berger Hospital, Circleville. The guest speaker was Dr. W. P. Smith, Columbus, who spoke on "Diseases of the Breast".—News Clipping.



Boyd C. Bly, M.D., Bryan; Ohio State University, College of Medicine, 1925; aged 39; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 13 following a year's illness. Dr. Bly had practiced at Tippecanoe City, Springfield and Montpelier before locating in Bryan. He was a native of West Unity. His parents survive.

Willard B. Carpenter, M.D., Columbus; Hahnemann Medical College and Hospital, Philadelphia, 1879; aged 78; died September 19. Dr. Carpenter had practiced in Columbus for nearly 60 years. He was one of the founders of the Columbus Mutual Life Insurance Company. Dr. Carpenter belonged to the Presbyterian Church, Masonic and Odd Fellows lodges, Sons of the American Revolution and the Optimist and University clubs. His widow and one brother survive.

Oscar B. Dunn, M.D., Ironton; Miami Medical College, Cincinnati, 1878; aged 84; former member of the Ohio State Medical Association and the American Medical Association; died September 11. Dr. Dunn, a native of Ripley, had retired from active practice seven years ago following injuries received in an automobile accident. He had practiced in Ironton for 50 years. He belonged to the Masonic Lodge and Methodist Episcopal Church. Surviving are three sisters and one brother.

William E. Hart, M.D., Elyria; Western Reserve University, School of Medicine, 1886; aged 72; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 24 of heart disease. Dr. Hart had served for many years as secretary-treasurer of the Lorain County Medical Society and was known as one of the most efficient and

alert county society secretaries in Ohio. He was a captain in the medical corps during the World War. Two sons survive.

Rufus C. Pennywitt, M.D., Dayton; University of Louisville, Louisville, Ky., 1896; aged 62; former member of the Ohio State Medical Association and the American Medical Association; died of heart disease, September 18. Dr. Pennywitt was a native of Manchester, locating in Dayton 35 years ago. He was a member of the Masonic Lodge and the Northmoor Country Club.

Robert G. Reed, M.D., Cincinnati, Pulte Medical College, Cincinnati, 1889; aged 73; died September 17. Dr. Reed was a native of Logan County and had resided in Cincinnati since 1889. He retired from active practice three years ago. His widow, one daughter and two sons, one of whom is Dr. H. E. Reed, Dover, survive.

Dale L. Walker, M.D., St. Clairsville; Jefferson Medical College, Philadelphia, 1885; aged 74; died September 8. Dr. Walker retired from active practice nine months ago.

KNOWN IN OHIO

Herbert C. Haskins, M.D., Maintou Beach, Devil's Lake, Michigan; Toledo Medical College, 1896; aged 80; died September 16. Dr. Haskins had practiced in Toledo until six years ago when he retired because of his health, moving to Michigan. His widow and one sister survive.

— OSMJ —

Health Commissioners' Conference, November 14 to 16 Has an Attractive Program

Fifteenth Annual Conference of Health Commissioners with the State Department of Health will be held in Columbus at the Deshler-Wallick Hotel, November 14, 15 and 16.

The first session will be held on Wednesday afternoon, November 14, starting at 2:30 o'clock and will be officially opened with an address of welcome by Governor George White. Following the annual address of the State Director of Health, Dr. H. G. Southard, Dr. Frank G. Boudreau, acting chief of the Health Section of the League of Nations, Geneva, Switzerland, will speak. Dr. Boudreau, formerly connected with the State Department of Health, is ranked as one of the world's leading authorities on public health questions.

The Thursday morning, November 15, session will open at 9 A. M., with Dr. W. D. Bishop, health commissioner of Darke County and Greenville, presiding. The following address will be presented:

"Tuberculosis in Children and the Mantoux Test", Dr. H. J. Gerstenberger, Cleveland; "Necessity for Correct Vital Facts", I. C. Plummer, chief of the Division of Vital Statistics, State Department of Health; "Epidemic Encephalitis", Dr. P. George Tait, Toledo; and "Post Graduate Work in Public Health", Dr. M. C. Hanson, health commissioner of Richland County and Mansfield.

A public health luncheon will be held at noon at which the principal speaker will be Dr. Arthur G. Helmick, Columbus. Dr. Helmick will discuss "Nutritional Fads and Facts from the Viewpoint of the Clinician".

The Thursday afternoon session will be presided over by Dr. R. D. Worden, health commissioner of Portage County. The following addresses will be presented:

"Public Health Principles Applied to Domiciliary Institutions", Dr. H. L. Rockwood, superintendent of Mt. Sinai Hospital, Cleveland; "Amoebiasis", Dr. Clayton C. Perry, Cleveland; discussion opened by Dr. Francis Bayless, Cleveland; "Feeding Garbage to Hogs", Dr. H. H. Pansing, health commissioner of Montgomery County; "Malaria Epidemic in Portage County", Dr. Worden.

Engineering problems will be discussed at the Friday, November 16, morning session, with F. H. Waring, chief engineer, State Department of Health, presiding. The following addresses will be made:

"Sealing of Abandoned Coal Mines", B. F. Hatch, sanitary engineer, State Department of Health; "The Milky Way", Dr. H. S. Allen, health commissioner of Ironton; "Milk Sanitation", M. J. Dotter, district supervisor of rural sanitation, U. S. Public Health Service, Columbus; "Rural Sanitation in Ohio", Dr. W. P. Johnson, assistant director of rural sanitation, State Department of Health; "Well Development", B. V. BeVier, sanitary engineer, State Department of Health.

Dr. G. T. Wasson, health commissioner of Crawford County and president of the Ohio Federation of Public Health Officials, will preside at the closing session on Friday afternoon, November 16. The following will speak: Dr. A. L. Van Horn, chief of the Bureau of Child Hygiene, State Department of Health, on "Child Hygiene in Ohio"; Miss Helen L. Felkner, R.N., field nursing representative, State Department of Health, on "Problems of Public Health Nursing", and Dr. Joseph W. Mountin, U. S. Public Health Service, on "Public Health Administration Under the County Government Amendment". A business session of the Ohio Federation of Public Health Officials will conclude the conference.

— OSMJ —

Cincinnati—Dr. Clarence A. Mills, professor of experimental medicine, University of Cincinnati, has been appointed by the Leonard Wood Memorial for the Eradication of Leprosy to make a study in the Philippines of climatic conditions and their relation to leprosy.

SURVEY ON SOCIAL-ECONOMIC FACTORS IN DISTRIBUTION OF PHYSICIANS IN OHIO

As emphasized frequently by medical leaders who have given serious study to problems which have arisen relative to the distribution and costs of medical service, these questions should not and cannot be solved or even be given fair and comprehensive study without appropriate consideration of social and economic factors and conditions of general application and effect.

It has been contended, and logically so, that certain problems involved in bringing about a more equitable distribution of medical services and readjustment of the costs of sickness to meet the financial conditions of certain groups of society cannot be directed by the medical profession single-handed, and without regard for certain basic social and economic factors.

Additional evidence to support this viewpoint is constantly being produced, substantiating the opinion that medical service is greatly affected by conditions and developments which affect the social and economic status of society generally.

Interesting and significant data bearing on this question is found in a publication recently issued by Professor C. E. Lively of the Agricultural Extension Service, Ohio State University, entitled "Some Rural Social Agencies in Ohio". The publication is a revised edition of an earlier publication issued in 1923 and contains facts and statistics regarding the distribution and activities of certain organizations, agencies and services operating in rural Ohio during the period 1921-1931.

A portion of the publication is devoted to studies of public health services in rural communities, rural medical service and hospital service as it affects the agricultural communities of the state.

In a sub-chapter entitled, "The Rural Physician", Professor Lively reveals that urban Ohio with 67.8 per cent of the total population of the state in 1930, claimed 84 per cent of the total supply of physicians in 1931. His studies show that in 1931 there was one physician for every 768 persons in Ohio; in urban Ohio the number of persons per physician was 618, and in rural Ohio the number of persons per physician was 1572, indicating that the supply of physicians is unevenly distributed between county and city.

"During the last 20 years, "Professor Lively points out, "the number of persons per physician has increased much more rapidly in the rural districts than in the urban. This condition has resulted from the migration of rural physicians to the urban districts and the failure of recent graduates to locate in the smaller places; hence, it has come about that the distribution of physicians between city and country was more unequal in 1931 than at any time during previous 20 years.

"Many explanations of the rapid decline in the number of rural physicians have been offered. It is clear that the problem is a complex one and cannot be explained by a single factor. Any complete set of causative factors must explain why rural physicians have migrated to urban locations for practice and also why more recent medical graduates have not located in rural districts.

"It is well to remember in this connection that during the 20-year period prior to 1930 certain fundamental changes in the social order were in progress. Cities were growing rapidly, and the great expansion of the means of communication, particularly the automobile, brought the rural population into contact with the cities as never before. It was a period of rising prices, rising incomes, and rising standards of living. More and more rural people looked to the larger towns and cities to obtain the goods and services which they regarded as necessary for the further enrichment of their respective planes of living. Medical service was no exception. Rural people with capacity to pay increasingly turned to the city specialist and the urban hospital as a means of obtaining the latest in medical service. The rural practitioner tended to lose his most profitable customers and migrated to a larger town where he could equip an office with the latest devices so much in demand and where he could also obtain the living conveniences of the larger community.

"In the meantime, rising medical standards and the capacity of the people to pay brought an unprecedented development of specialism in medicine. Hospital facilities grew apace. The function of the general practitioner tended to be overlooked. Medical graduates were trained to practice in hospitals and hospitals are located in cities. There was concentration of physicians in large cities known to be medical centers. It is not surprising that under these circumstances the proportion of medical graduates locating in rural districts dwindled."

Professor Lively does not undertake to suggest ways of solving the problems of medical service which exist in some sections of the state but the factual data which he offers indicates that these problems will not and cannot be solved independently of efforts to solve the underlying social and economic problems which were largely responsible for them.

Adjustment of basic economic and social factors which have brought about unsatisfactory conditions in both rural and urban communities will, when accomplished, have a beneficial effect on the distribution and costs of medical service throughout the state generally.

NEWS NOTES of OHIO

Hilliards—Dr. William L. Pritchard, formerly an interne at St. Francis Hospital, Columbus, has opened offices for general practice here. He is the son of Dr. William L. Pritchard superintendent of the Columbus State Hospital.

Cleveland—Dr. Howard T. Karsner, professor of pathology, Western Reserve University, and Mrs. Karsner have returned from Europe where Dr. Karsner visited laboratories at London, Hamburg, Paris and Munich, and attended a pathological conference in Holland.

East Liverpool—Dr. John A. Fraser, Mrs. Fraser and their three daughters have returned from an eight-weeks trip through Scotland, where Dr. Fraser took post-graduate work in obstetrics, gynecology and surgery at the University of Edinburgh.

Cincinnati—Dr. Samuel Iglauer was elected a vice president of the American Academy of Ophthalmology and Otolaryngology at its recent meeting in Chicago.

Deshler—Dr. Arnold D. Piatt, who recently completed his internship at the Newark Memorial Hospital, Newark, N. J., has opened offices here. He is a brother of Dr. L. M. Piatt, Ottawa.

Carey—Dr. Robert Semons, former intern at Good Samaritan Hospital, Dayton, has located here.

Archbold—Dr. Edwin R. Murbach opened offices here recently for the active practice of medicine, becoming an associate of his father, Dr. E. A. Murbach and his uncle, Dr. C. F. Murbach. He is the third generation of physicians in the family to practice here, his grandfather, the late Dr. A. J. Murbach, having practiced in Archbold for many years.

Forest—Dr. B. L. Johnson has been commissioned a first lieutenant in the Medical Reserve Corps.

Toledo—Dr. W. W. Randolph and Dr. Leonard Nippe have returned from postgraduate work in bronchoscopy at Philadelphia.

Dunkirk—Dr. S. P. Churchill, former intern at St. Rita's Hospital, Lima, has opened offices here.

Wooster—Dr. A. J. Hartzler, who recently completed his internship at Mt. Carmel Hospital, Columbus, has opened offices here.

Pomeroy—Dr. George L. McCullough has become an associate of his father, Dr. S. A. McCullough, in active practice here. He is a grandson of Dr. G. B. Hensley, Meigs County, and a great grandson of the late Dr. J. L. Hensley, Marion.

Dover—Dr. William E. Hudson, formerly physician at the Ohio State Sanatorium, Mt. Vernon, has opened offices in the Bruck Building here and is specializing in diseases of the chest.

Wilmington—Dr. Kelley Hale addressed chapel services at Wilmington College recently.

Martins Ferry—Dr. Harry Harris has returned from Chicago where he took postgraduate work at the Cook County Hospital.

Springfield—The engagement of Miss Ruth T. Crabill, this city, and Dr. Edward S. Young, Lakeside Hospital, Cleveland, has been announced.

Middleport—Dr. C. A. Poindexter has resumed active practice following a long convalescence from injuries received in an automobile accident.

Columbus—Dr. and Mrs. Joseph Price have returned from a several months' trip through Europe.

—OSMJ—

Death Rate In Ohio Increases In First Six Months of 1934

An increase of 16 deaths each day in Ohio is shown by a comparison of the number of deaths for the first six months of 1934 with the same period in 1933, according to the Division of Vital Statistics, State Department of Health. In this increase is found tuberculosis (all forms), the first time an increase has been noted in the number of deaths from this cause since 1926.

The death rate for the first six months of 1934 is 11.6 per 1000 population, as compared with 10.9 for the same period in 1933. Increases were recorded in most of the important causes of death and decreases only in the following: Influenza, lethargic encephalitis, diarrhea and enteritis (under two years of age), the puerperal state, malformations and diseases peculiar to early infancy, suicides and homicides. The greatest increase was reported in diseases of the respiratory system, 1367 more for this period in 1934 than in 1933, in spite of the fact that there was a decrease of almost 400 deaths in influenza.

It has been evident by the reports to the Division of Communicable Diseases this year that there was unusual prevalence of communicable diseases in Ohio. Checking the tabulation in the Division of Vital Statistics, there were found more deaths from communicable diseases than for the period last year.

Violent deaths increased in almost every cause, as 16 graves were dug every day in the state to take in bodies of persons whose death was due to

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accident. The increase in fatal accidental falls was 114; increase in deaths due to automobile accidents, 113.

The number of deaths deported for the first six months of this year was 40,683; last year, 37,705.

Tabulated below are the principal causes of death, with rates per 100,000 population for the first six months of 1933 and 1934:

	No. 1933	No. 1934	Rate 1933	Rate 1934
Typhoid fever	32	34	.93	.97
Smallpox				
Measles	104	132	3.01	3.78
Scarlet fever	120	146	3.47	4.18
Whooping cough	72	198	2.08	5.67
Diphtheria	65	70	1.90	2.00
Influenza	1188	792	34.40	22.68
Acute anterior poliomyelitis	10	4	.28	.11
Lethargic encephalitis	40	25	1.15	.71
Epidemic cerebrospinal meningitis	21	39	.61	1.12
Rabies		1		.02
Tuberculosis (all forms)	1901	1915	55.00	54.84
Cancer (all forms)	3790	3928	109.75	112.49
Diabetes	792	884	22.93	25.31
Diseases of nervous system	4393	4787	126.21	137.10
Cerebral hemorrhage	3698	4004	107.09	114.67
Diseases of circulatory system	9652	10178	279.52	290.50
Diseases of the heart	8589	9075	248.73	259.90
Diseases of the respiratory system	2631	3998	76.19	114.65
Pneumonia (all forms)	2305	3491	66.75	99.98
Diseases of the digestive system	2043	2139	59.16	62.26
Diarrhea & enteritis—under 2 yrs.	124	120	3.59	3.43
Diseases of genitourinary system	3240	3548	93.83	101.61
Nephritis	2856	2991	82.70	85.86
The puerperal state	309	296	8.94	8.47
Malformation & diseases peculiar to early infancy	1576	1534	45.64	43.93
Suicide	660	577	19.11	16.53
Homicide	247	228	7.15	6.52
Conflagration	45	58	1.30	1.66
Accidental burns conflag'tion ex.)	136	144	3.93	4.12
Accidental falls	595	709	17.23	20.30
Railroad accidents	130	143	3.76	4.10
Streetcar accidents	39	22	1.12	.63
Automobile accidents	663	776	19.20	22.22
All other accidents	988	1077	28.61	30.84
Total accidents	2596	2929	75.16	83.88
All other causes	2221	2302	64.32	65.92
Grand Totals	37705	40683	1091.93	1165.16

— OSMJ —

Payment of Water Bills of Indigents Is Held Legal

In a recent opinion of the Attorney General (No. 3252, Sept. 26,1934), the question of delinquent water bills in municipalities and how they shall be paid is discussed. The opinion is rendered to the State Relief Commission and relates specifically to the use of relief moneys in the City of Columbus for the payment of water bills incurred by indigents.

Since the question of continued water service involves problems of sanitation and public health, some of the highpoints of the opinion are herewith reviewed.

Four points are covered in the opinion and are briefly as follows:

1. The following is quoted verbatim:

Water is even more essential to the relief of indigent persons than is food, shelter and clothing, and in my opinion, the payment of the water bills of indigent persons having legal settlement within the city is a tye of "relief" authorized by Section 3476, General Code * * *.

2. The statement is made that "There is no authority for the city to furnish free water directly to indigent persons of the community". In

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For Sale—Morse Wave Sinusidal Current only. Good condition. Will ship C. O. D. $35.00. Address K. B., care *Ohio State Medical Journal.*

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other words, inasmuch as a public water supply of a municipality is a public utility and water which is used must be paid for in the same manner as electric current, gas, transportation and other utilities, the water department cannot be made an agency for the provision of relief.

3. In response to the direct inquiry, the Attorney General stated that "It is my opinion that the State Relief Commission may, if the City of Columbus is unable to furnish necessary and adequate relief for its indigent persons in the way of payment of their water bills, grant funds from the State Emergency Relief Fund to such subdivision for such purpose * * *".

4. The question of rented property is discussed. In cases where an indigent tenant is in arrears in his water bill and where the contract for the water service is between the city and the non-indigent property owner, it is held that there is no authority for the payment of the water bills from poor relief funds. However, if the contract is between the city and the indigent tenant then it is held that payment of the bill would constitute furnishing aid to the indigent himself and the funds could be secured from poor relief funds. As a further aid, it is pointed out that in extreme cases, where a tenant is suffered to remain in the property but the property owner, liable for the water bill, orders the water shut off, water bills of indigent persons from that period on could legitimately be paid out of poor relief funds.

The opinion renders a distinct aid to municipalities that have been more or less perplexed with the problem of the continuance of water service. There can be no question as to the necessity of this continued service from the standpoint of both sanitation and public health, and it is vital in the opinion of public health officials that some means be worked out whereby premises depending on a public water supply shall continue to have that service.

— OSMJ —

—Dr. E. A. Freeman has been elected chief of staff of Akron City Hospital, succeeding Dr. A. S. Robinson, retiring senior member of the executive committee. Dr. E. R. C. Eberhard was chosen chairman of the executive committee, other members of which are Dr. C. C. Pinkerton, Dr. D. B. Lowe and A. E. Hardgrove, superintendent. The program committee for the ensuing year will be Dr. John H. Weber, chairman, Dr. S. Morgenroth and Dr. S. B. Conger. Personnel of the library committee is Dr. C. R. Steinke, chairman, Dr. J. N. Weller, Dr. R. T. Allison, and Dr. H. V. Sharp. The intern teaching committee consists of Dr. W. J. Ream, chairman, Dr. E. L. Saylor, and Dr. G. A. Ferguson.

— OSMJ —

Ashland—Dr. Malcolm Miller, who recently completed his internship, has established offices with Dr. George Riebel.

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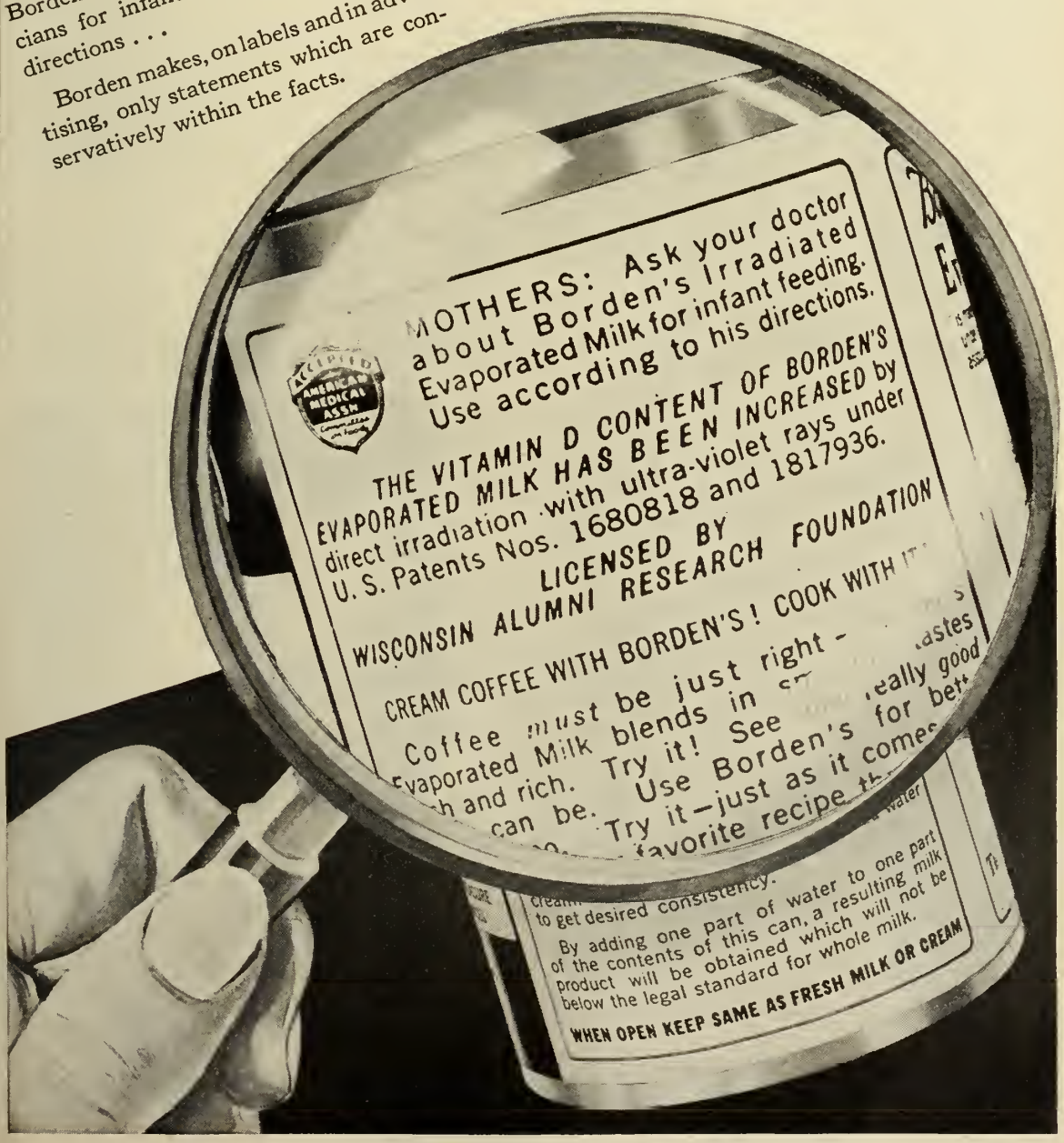
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A Plan to Evaluate Independently Serologic Procedure for the Diagnoses of Syphilis in the United States

Since the serologic conferences at Copenhagen and Montevideo, there has been an increased interest in the relative value of serologic tests for the diagnosis of syphilis. At these conferences the test of only one serologist of the United States was presented for consideration. There are a number of excellent serologists in this country, many of whom have described original modifications of the complement-fixation and precipitation tests for syphilis. It is felt that the tests of these workers merit consideration.

The United States Public Health Service is cooperating with the American Society of Clinical Pathologists in the drafting of a plan to evaluate independently serologic procedure for the diagnosis of syphilis in this country. Briefly, the plan contemplates the collection of specimens of blood from at least 1,000 individuals and the distribution of comparable specimens to the laboratories of serologists who have described an original modification of a complement-fixation or precipitation test for the diagnosis of syphilis. The donors of the specimens will be carefully selected so as to measure both the specificity and sensitivity of the serologic procedure. The sending of specimens to workers at considerable distance from the point of collection will be expedited by the use of the most modern transportation facilities, while the delivery of specimens to nearby serologists will be delayed so as to make the delivery time approximate that for those workers at the more remote points.

A committee of five members consisting of two specialists in the field of clinical syphilology, two members of the American Society of Clinical Pathologists, and one officer of the United States Public Health Service will organize the plan of study and, after all laboratory reports have been submitted by participating serologists, will interpret the results on the basis of clinical findings. The collection of the specimens will begin about December 1, 1934, and a number of serologists will be invited to take part in the evaluation scheme.

It is possible that the name of some serologist who has described an original modification of a test for syphilis may have been inadvertently omitted. Any serologist desiring to participate will be extended an invitation upon presentation of suitable proof as to the originality of his modification of a serologic test. A brief description of the plan will also be sent to those workers who may be interested.

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Relative Values of Carbohydrates Employed in Infant Feeding

Continued down from 1911

1916

"For the addition of sugar, I usually use dextri-maltose, which does not easily cause fermentation."—*L. L. Meininger: Use of Eiweissmilch, Arch. Pediat., 33:529-532, July, 1916.*

1916

In the treatment of marasmus, "Three per cent of malt sugar should be administered from the first, afterwards running up to as high a per cent as the child will take."—*L. T. Royster: A Handbook of Infant Feeding, C. V. Mosby Co., St. Louis, 1916, p. 100.*

1916

"Least irritating of all sugars, and more readily digested and quickly absorbed, is maltose."—*H. Lowenburg: A Practical Treatise on Infant Feeding and Allied Topics, F. A. Davis Co., Phila., 1916, p. 73.*

1916

"Dextrin-maltose is valuable in cases where intestinal disturbances are due to fermentation of milk sugar."

"Treatment (of sugar intoxication) consists in eliminating the latter (whey salts) as well as the sugars from the diet temporarily, and when the symptoms have subsided, a different sugar in proper proportion should be cautiously added; maltose and dextrin are preferable, because they are not apt to produce fermentation, while milk sugar is prone to set up fever and diarrhea."—*E. E. Graham: Diseases of Children, Lea & Febiger, Phila., 1916, pp. 179-201.*

1917

"For children who are not gaining on a normal formula with a sufficient amount of sugar of milk, or children who vomit when sugar of milk is fed, or who are constipated, the use of maltose instead of lactose often gives most satisfactory results. This is readily accomplished by substituting for the 4 or 5 per cent. of added sugar of milk an equal amount of dextri-maltose or malted milk, which latter gives, in addition to the maltose, some protein food and an insignificant amount of fat. In many cases children who have failed to gain on other food will immediately show a marked gain as soon as this change is made."—*R. G. Freeman: Elements of Pediatrics. Macmillan Co., New York, 1917, pp. 191 and 192.*

1917

"The carbohydrates most used in infant feeding are the three soluble sugars and starch. The three soluble sugars are lactose, or milk sugar, maltose, or malt sugar, and saccharose, or cane sugar. Maltose is not used in its pure form, on account of its cost. The various commercial preparations of maltose are combinations of maltose with various dextrins, but as in digestion dextrin is converted into maltose, the chemistry is practically the same."

"The sugar which is not absorbed is broken down by the bacteria of the intestine into a great variety of fermentation products, among them being lactic, butyric, acetic, and succinic acids."

"Another effect of the excessive fermentation which results from a relative excess of carbohydrate in the food, is the formation of an excessive amount of gas. This may cause abdominal distention, and, extending backward, it may carry irritating acid products into the stomach, and thus cause vomiting."

"Lactose is the sugar most likely to produce acute symptoms. The stools are practically always green and very irritating. Flatulence and colic are less prominent."

"The maltose-dextrin preparations rarely produce acute exacerbations."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, pp. 423, 424, 425, 428.*

1918

"The sugars in the foods are milk sugar which is found in mother's milk as well as in cow's milk, cane sugar and malt sugar. Though milk sugar is a natural ingredient of milk it is not well borne by babies when added to their food; they digest cane sugar, the ordinary granulated sugar, much better; malt sugar is the easiest digested by babies."—*C. G. Leo-Wolf: Nursing in Diseases of Children, C. V. Mosby Co., St. Louis, 1918, p. 24.*

1918

"Maltose (malt sugar) has the advantage of being very easily digested; when part of the sugar given is maltose, many children gain more rapidly in weight than when only milk sugar or cane sugar is used."—*L. E. Holt: The Care and Feeding of Children, D. Appleton & Co., New York, 1918, p. 66.*

1919

"In the administration of protein milk with its large protein content, by adding to it sugar which is not easily fermented (dextri-maltose), we produce, instead of pathologic fermentation, a condition of putrefaction which changes the acidity of the intestinal contents to alkalinity, the peristalsis is decreased, the intestinal contents pass slowly through the large intestines with absorption of fluid and excretion of calcium and magnesium salts. These minerals unite with fatty acids to form the typical fat-soap-clay-coloured constipated stools characteristic of protein milk feeding, and it is at this point that dextri-maltose should be added to the food."

"The majority of the cases were kept on protein milk for a period varying from three to four weeks, and, in many instances, contrary to the usual opinion, we were able to keep the children on protein milk plus starch and dextri-maltose, sufficient for their caloric needs for a period of several months, in each instance accompanied by a substantial gain in weight and normal increase in vigor and tissue turgor with comparative freedom from digestive symptoms."—*A. Brown and I. F. MacLachlan: Protein milk powder, Canad. M. A. J., 9:528-537, June, 1919.*

1920

"There are three sugars commonly employed in infant feeding: (1) malt sugar or dextri-maltose, (2) cane sugar, and (3) milk sugar. Malt sugar is the most easily digested and assimilated, cane sugar next and sugar of milk the least so."—*L. O. Frech: The caloric method of artificial feeding in normal babies, Illinois M. J. 38:484-488, Dec. 1920.*

1920

Regarding treatment in disturbed metabolic balance in infants, "The one carbohydrate which seems to give the most satisfactory results in these cases is malt sugar."—*C. H. Seybert: Disturbed metabolic balance in infancy, Hahneman, Monthly, pp. 379-382, June, 1920.*

1921

"Next to woman's milk is cow's milk in simple modification with water and sugar in proper proportions and amount according to the age of the child. Milk Sugar is the most expensive and least satisfactory sugar. Dextri-Maltose is the best sugar."—*A. A. Shawkey: Infant foods and infant feeding, West Virginia M. J. 15:284-287, Feb. 1921.*

1921

With reference to hypotrophy, "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially fed infants, New York M. J. 114-158-160, Aug. 1921.*

1921

"Maltose and dextrin compounds are acceptable to the infant's digestion in relatively larger quantities. They are not as sweet as cane sugar. They are of practical value when larger amounts of cane sugar are not well borne.

"The so-called 'Mead's Dextri maltose with Potassium Bicarbonate' is laxative, and in the presence of a stationary weight may be given in larger amounts."—*F. W. Fergusson: A method for the modification of cow's milk, Journal-Lancet, 41:628-629, Dec. 1, 1921.*

1921

For cases of fermentative diarrhea, ". . . the ideal plan of treatment would be to give a food which is low in sugar (the food which that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextri-maltose to the formula."—*A. G. DeSanctis and L. V. Paider: The value of calcium caseinate milk in fermentative diarrhea, Arch. Pediat. 38:233-236, April, 1921.*

1922

In the treatment of diarrhea, "The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose."—*H. E. Small: Diarrhoea in bottle-fed infants, J. Maine M. A. 12:154-158, Jan. 1922.*

1922

"The use of other soluble carbohydrates other than lactose for milk modifications are very good. Some believe the addition of dextrose or dextri-maltose makes the casein curd softer and easier to digest. This is questioned, but all agree that in cases of malnutrition, where the patient is intolerant to lactose and cannot get the benefit needed from the fat in the diet that the dextri-maltose is invaluable as it is the easiest sugar to digest, and can be immediately used for energy production without undergoing further change."—*E. G. Padfield: Remarks on infant feeding, J. Kansas M. S. 22:97-101, April, 1922.*

Continued down to 1934

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Effect of Person's Job on Length of His Life is Studied

What effect has a man's job on the length of his life? An answer to this question is offered by Miss Jessamine S. Whitney, statistician, National Tuberculosis Association, in a report of a five-year study conducted under her supervision, and made public recently by the association.

The highest death rate from all causes, for working men, 15 to 64 years of age, was found among hostlers and stable hands, 36.22 deaths per thousand employed. The rate for garage laborers of the same ages was only 6.65. The rate for operatives in harness and saddle factories was 30.55; for aviators, 28.73; for operatives in cigar and tobacco factories, 19.32, which was also the rate found for boatmen, canal men and lock-keepers. Sailors and deck hands had a rate of 17.28. These may be compared with school teachers, with a rate of 4.42, and social and welfare workers, with a rate of 2.75, or with the rate for all "gainfully employed males," aged 15 to 64 of 8.70 per thousand. In the public service, guards, watchmen and doorkeepers died at the rate of 20.25 per 1,000. Firemen showed a rate of only 6.71. General laborers in the public service had a rate of 7.15, but garbagemen were found to have an index of 11.39. The rate for postmasters was higher than that for mail carriers, the figures being respectively 11.00 and 6.10.

Other comparisons taken from the report are: lawyers, judges, and justices, 7.89; physicians and surgeons, 10.69; clergymen, 10.33; cemetery keepers, 6.50; college presidents and professors, 2.69. Rates for laborers in the chemical and allied industries were low at 5.13, and laborers in soap factories, 3.29, while for inventors, the rate is 17.65 and for draftsmen 3.21. Managers and officials of real estate companies have a rate of 5.64, but for real estate agents it is 10.09. Chauffeurs and truck and tractor drivers, 6.19; draymen, teamsters and carriage drivers, 17.59; telegraph operators, 10.09, and telephone operators, 4.59.

The report contains eight detailed and comprehensive tables, accompanied by interpretative comment. One of these tables shows death rates for various occupations by broad age groups according to cause of death. Suicides among lawyers, judges, and justices are less than the average for all gainfully employed males included in the study; among doctors, suicides are greater. Unskilled workers kill themselves in greater proportion to their numbers than professional men, and agricultural workers less than semi-skilled workers in other pursuits. Tuberculosis takes its greatest toll among unskilled workers, whose rate is double the average for all workers; the rate for skilled workers is a little under the average; while professional men have a rate less than one-third of the average. After the age of 45, heart

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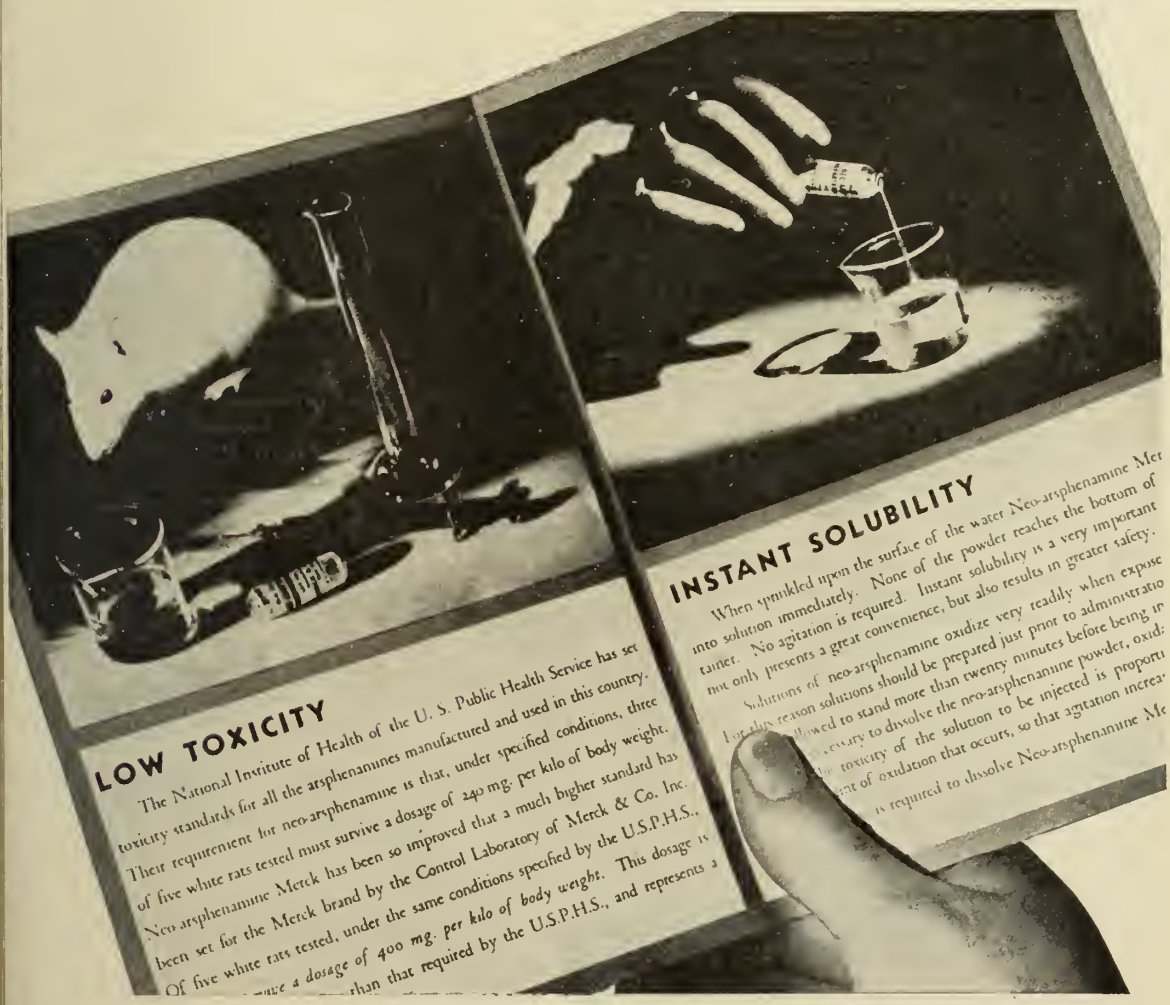
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disease claims more than the average of professional men; but the rate for agricultural workers is only half the average, and unskilled workers again seem to get the worst of it from heart disease, with the highest rate, for both the 25 to 44 and 45 to 64 age groups.

The importance of the study is pointed out by Miss Whitney who says in the report: "Without accurate data as to the relative health risk of various occupations, no one knows where to expend the greatest effort in industrial health work. Each industry has come to realize that certain of its occupations are more hazardous than others. Employees in dusty trades, those usually exposed to high temperature or to excessive moisture, or to bad weather conditions generally, are among the workers subjected to the greatest risk. That a certain occupation may be hazardous may be a recognized fact. But how hazardous is it? How much more dangerous is it than other occupations in the same or other industries?

"Not only is one's chance of survival affected by the hazard directly inherent in the job, as in the case of metal filers and zinc miners, etc., but there is too the effect of social or economic status or of different standards of living, as implied by certain occupations. For example, the lowest rate from tuberculosis is found in the highest economic bracket, and the rates increase steadily through the other social-economic groups, (with the exception of agricultural workers) the highest tuberculosis death rate occurring in the lowest social-economic group."

— OSMJ —

Measles Particularly Dangerous to Children of Pre-School Age

Measles is a disease of particular peril to the pre-school child and should not be treated lightly by parents and physicians, according to an article published in a recent issue of the *Ohio Health News*. Commenting on the disease and statistics on it in the files of the State Department of Health, the *Health News* stated:

"There have been reported in Ohio, during the last six years, 160,086 cases of measles, of which 15,600 were reported in 1933, comparing with 37,969 in 1932. Reported deaths, last year, were 117, making a measles mortality rate per 100,000 population of .169, compared with 163 deaths and a rate of 2.38 in 1932. The average measles mortality rate for 11 years has been 2.179.

"These death rates do not seem very high, but when it is considered that a vast majority of deaths from measles is among infants under two years of age, the seriousness of an epidemic may be realized. Most of the cases in neighborhood epidemics are among school children and, proportionately, few of them die. Those in peril are the pre-school children, and the *younger the child when he contracts the disease, the more readily he succumbs.*

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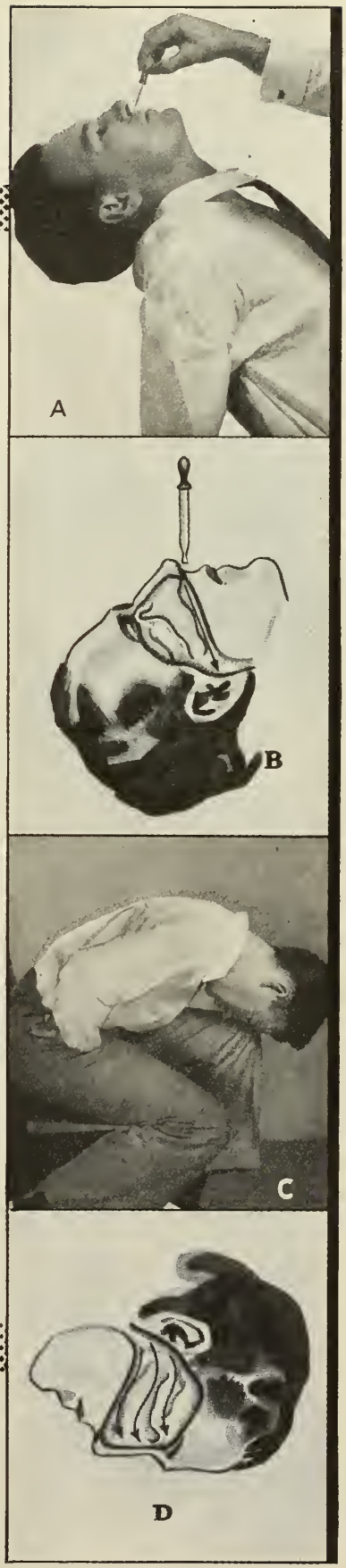
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DECEMBER 1, 1934 VOLUME XXX
Number 12

SOCIALIZATION OF MEDICINE BECOMES VITAL ISSUE AS WHITE HOUSE ADVISORS DISCUSS SOCIAL INSURANCE PROGRAM—SEE PAGES 827 TO 833

* * * *

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Ohio State Medical Journal

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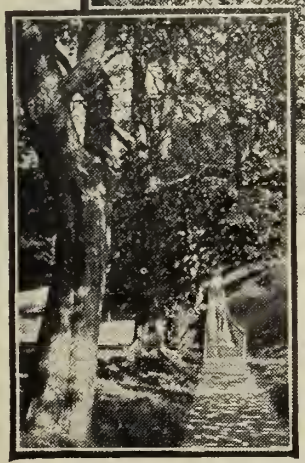
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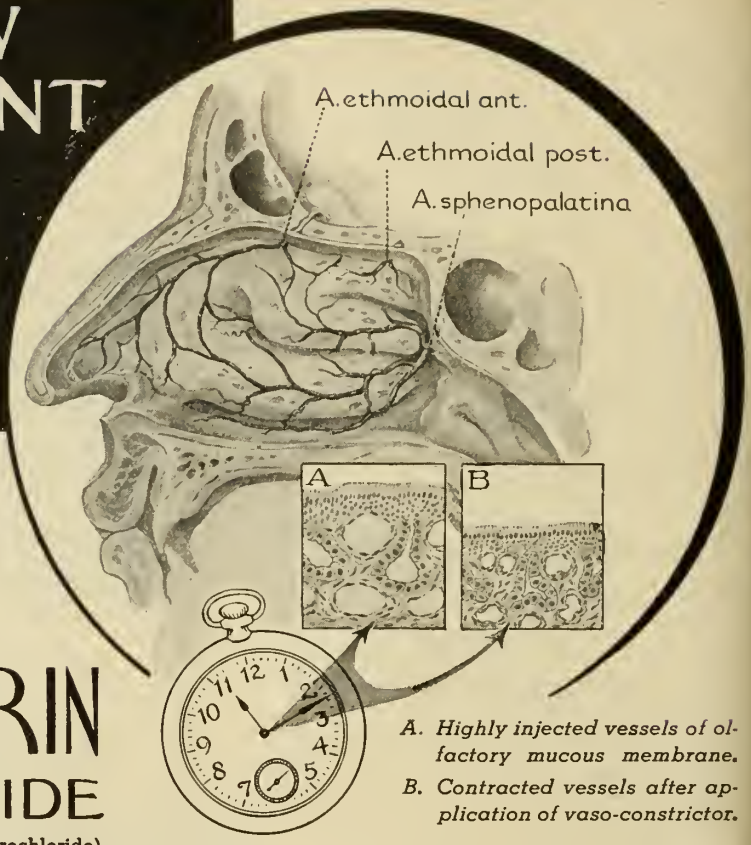
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"The Milk Question"

by M. J. ROSENAU, Professor of Preventive Medicine and Hygiene, Harvard Medical School.

"Man has but a single stomach and this forms about twenty per cent of the digestive tract. The cow has four stomachs which form about seventy percent of the digestive tract. The calf's stomach is well fitted to handle and digest the tough, lumpy curds which form from cow's milk. Woman's milk curdles into a soft mass which is broken into numberless small particles. Evidently the stomach of the infant fed with cow's milk is over-taxed trying to break the tough curds into particles small enough for complete digestion. It is therefore evident that even if we could secure cow's milk, the chemical composition of which was exactly the same as that of human milk, it would still be far from a perfect substitute unless it behaved similarly in the digestive tract."

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Physicians and Legislators

The 91st regular session of the Ohio General Assembly, the members of which were elected by the voters of the state at the recent general election, will open in Columbus on Monday, January 7.

Coming in the midst of a period of economic uncertainty, social unrest, general sentiment for experimentation, agitation for reforms in government, sweeping changes in the relationship between government and the public, and numerous other developments directly affecting social concepts and relations, the next session of the State Legislature should be regarded by every citizen of Ohio as an event which may mark the beginning of a new chapter in the history of Ohio.

Members of the 91st General Assembly will be called upon to act upon numerous vital questions, affecting in one way or another the lives and future of every citizen of the state.

Their decisions may alter in many respects the character and scope of our present system of government itself.

More depends now than ever before on the character and attitude of those chosen to represent the people of Ohio in a legislative capacity.

This also applies to those elected to represent Ohio in the next United States Congress.

The fate of Ohio, as well as the nation as a whole, depends to a large extent on the actions of those selected for legislative responsibilities during the ensuing months.

It is not strange that the medical profession should view the forthcoming sessions of the State Legislature and Congress with unusual anxiety and apprehension.

Unprecedented difficulties are in store for the medical profession during the coming year.

Recent events and developments directly affect-

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Also Membership Dues

THE envelope containing this issue of your *Journal* bears the admonition "Annual Subscriptions Expire With This Issue".

Postal regulations permit the subscription announcement to be carried on the *Journal* envelope, but do not permit reference to "annual dues", hence the wording as it appears.

However, as you know, subscription to *The Journal* is included in your annual dues to the Ohio State Medical Association which are *payable in advance.*

Dues for the calendar year 1935 should be paid *immediately* to the secretary-treasurer of your County Medical Society in order that the proportion of annual State Association dues may be transmitted by him *before* January 1 to the State Headquarters Office.

Annual dues in the State Association for 1935 paid and transmitted before the first of the year, mean continuous good standing in medical organization; continuous receipt of *The Journal;* and material assistance to your local and state officers and committees.

It is hoped that every member will read the "President's Page" in this issue of *The Journal,* on which Dr. Caldwell analyzes in a comprehensive manner the vital reasons for strong and active medical organization, especially at this time, and the benefits derived by every physician from membership in the Ohio State Medical Association.

ing medical practice and scientific medicine clearly indicate what some of these will be.

Much social legislation affecting the medical profession and medical practice will be introduced in the coming State Legislature and in Congress.

Powerful and active forces are making a determined drive for the enactment of legislation calling for compulsory health insurance and socialization of medicine, either on a national or state basis or both.

Great pressure is being brought to bear on the members of Congress and on the members of the legislative bodies of every state, including Ohio, to support legislation providing for radical changes in the present system of medical care.

This pressure comes from influential and well-financed groups whose activities and proposals have the approval of some of the close advisers to the present national administration.

Elsewhere in this issue of *The Journal* is published information concerning this strong movement for the socialization of medicine, following up articles on the same subject carried in previous issues during the past eight months.

Members of the profession who have observed these recent trends and developments are well-aware of the crisis confronting the medical profession.

To those who have so far failed to realize the impending dangers to scientific medicine and medical practice, it is respectfully suggested they review the comments which have been published from time to time in *The Journal* and make use of other means of informing themselves on the momentous questions involving the fate of medicine. Special attention is again called to the recent annual report of the Policy Committee published in the October *Journal*.

In addition, the medical profession may anticipate during the coming months bitter clashes with individuals and groups constantly endeavoring to undermine the medical and public health statutes.

Numerous types of anti-medical, cult and special-privilege proposals bearing on medical practice and public health are being formulated.

Supporters of these measures are prepared to make a desperate drive for their enactment at the next regular legislative session and because of the general spirit of unrest and sentiment for changes, regardless of rhyme or reason, in governmental policies, these groups are certain of securing an unusual amount of support for their proposals.

Much additional evidence is available to show that the coming regular session of the General Assembly will be turbulent and hectic, as well as challenging, to the medical profession of Ohio.

Issues and questions will have to be faced as they arise during the ensuing months and with all the concerted strength the profession is able to muster.

It has been said, and accurately, that physicians can, if they would, exercise a powerful influence, owing to the support which is obtainable from those to whom they have given professional care.

Now, more than ever before, it is vital that they utilize such influence. There must be no delay on the part of the profession generally in swinging into action. Now is the time for medical organization to lay the groundwork for the coming legislative session.

A physician, the same as every citizen, may make his influence definitely felt in relationship to proposed legislation by voicing his opinions and those of his associates directly to the members of the State Legislature and Congress from his county or district.

Needless to say, legislators *are* influenced in their attitudes and actions by their local constituents.

Many of them look to the members of the medical profession in their communities for advice and guidance on medical and public health questions. Those who do not should be so contacted that they will be willing to do so.

Personal contacts and conferences with members of the General Assembly and Congress should be arranged immediately by the proper representatives of medical organization in every part of the state, in an effort to create a willingness on the part of legislators to seek the counsel of medical organization on all medical and health matters.

It is quite likely that many difficulties and complex situations can be avoided if these and other public officials are given an opportunity *now* to understand the constructive and unselfish attitude of the medical profession on such questions and are made to realize that medical organization is the reliable, authoritative, permanent source of information on legislation in the field of health and medical practice.

Legislators who understand the proper medical viewpoint and who have the cooperation of the physicians of their communities are unlikely to give their support to plausible but vague or misleading proposals, or take action detrimental to scientific medicine and public health.

The responsibility of every physician in Ohio now is to create the right sort of sentiment locally on medical and health issues, for local sentiment, in the final analysis, guides members of the Legislature and Congress in most of their decisions and actions.

It is proper, desirable and practical for physicians as leading citizens to take an active part in all public and civic affairs, including governmental administration and legislation.

Because of their deep concern in medical and health questions, it is especially important they take a direct interest personally and through medical organization in governmental and legislative activities bearing on these questions.

More Funds For Industrial Commission An Urgent Problem

In an article in a recent issue of *Ohio Public Works*, C. H. Duncan, secretary of the Ohio Contractors' Association, comments on one of the biggest factors responsible for criticism made of the State Industrial Commission with respect to seemingly unnecessary and long delays in the settlement of claims and payment of fees of physicians, hospitals, nurses, and others for services rendered injured claimants.

Mr. Duncan made this observation:

"Those who have represented various groups of employers in Columbus and have had occasion to be in touch with the Commission at rather frequent intervals have noted with disapproval the legislative tendency to curtail the staff of the Commission. It has been particularly apparent that the Commission has been given insufficient personnel in the field. An institution of the character of the Industrial Commission can be no stronger or better than its field force. No private insurance company would undertake to operate with the limited field force available to the Industrial Commission."

This viewpoint coincides with that of representatives of the State Medical Association who have been in close and constant contact with the Commission and its administrative activities.

In fact, one of the major recommendations of the Special Workmen's Compensation Committee of the State Medical Association to the Governor's Investigating Committee on Workmen's Compensation was that a concerted effort be made to secure for the Commission sufficient annual appropriations for the employment of more and better-trained administrative personnel.

The medical profession should be deeply interested in this particular question inasmuch as the prompt payment of physicians' fees by the Commission depends on how rapidly the Commission is able to complete its investigation and adjudication of claims.

An active interest by members of the medical profession in anticipated efforts to have the State Legislature make more adequate funds available in the future for operation of the Industrial Commission will undoubtedly add impetus to the whole movement to put the workmen's compensation system on a more efficient basis.

Here is an opportunity for physicians to do something tangible to correct and minimize delay in the payment of medical bills, which at times sorely tries the patience of the best-natured members of the profession and which, in many instances, is the result of an insufficient number of employes in ratio to the steady flow of claims into the Commission's offices.

Reflections on Emergency Relief

One year ago the present Ohio plan under Federal Rules and Regulations No. 7, FERA, of providing medical care for the poor and unemployed had just been put into effect by the State Relief Commission.

The stormy voyage of the plan in Ohio during the past 12 months is well known to members of the medical profession. There is no need at this time to go into the history of how the plan has or has not functioned.

It may be of some interest, however, to Ohio physicians to know how the FERA No. 7 medical program has been working out throughout the country generally.

It is impossible now to give a detailed account of the experiences of some of the other states.

But, some of the observations of the American Public Welfare Association which has recently completed a study of the subject on a national basis are interesting and enlightening.

The following brief article published in a recent issue of *The Survey* summarizes the highspots of the welfare association's investigation:

"That the first year's work under FERA No. 7 made a good start toward establishment of a permanent medical-aid program is the conclusion of a study recently published by the American Public Welfare Association, 850 E. 58th Street, Chicago. (Medical Care for the Unemployed and Their Families, data compiled by Miriam Simons Leuck).

"Despite the spotty and sometimes meager use made by local communities under the federal provisions, disclosed by a survey made by the Association in cooperation with the Julius Rosenwald Fund, the association finds wide and effective education of communities in their responsibility to care for the sick poor and to pay the medical, dental and nursing professions for that care.

"Any permanent program, the association believes, must make allowances in procedure for the widely varying resources and demands in various sections of the country. More adequate statistics are needed.

"Lack of money, facilities and trained personnel and difficulties in adjusting relationships with the medical professions and local public health services have been drawbacks of the first year.

"Among its lessons are the discovery that to be successful the medical-aid program must have effective local supervision and control of costs, that hospitalization must be provided for in the future and greater provision made for the care of chronic illnesses and for special services."

Judging from these findings, it would seem that most sections of the country have encountered difficulties in connection with the present medical relief plan similar to those prevalent in Ohio.

No doubt many Ohio physicians will agree with

the editor of the *New Orleans Medical and Surgical Journal* who said, in commenting on the experiences of Louisiana physicians in connection with the FERA medical plan:

"When one observes the absence of a definite policy in the administration of the E.R.A. as to its relations with the physician, when one hears of conflicting orders and changed plans, when one notes the backing and side-slipping and irregular course of the E.R.A., one is impelled to remark with fervor, 'Lord help the medical profession if it ever comes under state supervision'."

— OSMJ —

Experiments In Social Medicine

It will be remembered that some months ago considerable discussion in the ranks of the medical profession took place following the approval on the part of the House of Delegates of the Michigan State Medical Society in special session of the general principles of an experiment in health insurance, titled "Mutual Health Service", recommended by a special committee of that society on medical economics following several years' inquiry.

At the time the Michigan House of Delegates endorsed the preliminary plan proposed by its special committee, it directed the committee to prepare the final details of such a plan and submit it for consideration at the regular annual meeting of the society this Fall.

When the House of Delegates of the Michigan society assembled some weeks ago, the economics committee reported that unforeseen circumstances had prevented the completion of the program and recommended to the House of Delegates three alternative courses of action on the question—to reverse its earlier position and discard its preliminary plan; to postpone action; or to re-affirm its previous action and continue with the mutual health service program.

As stated in *The Journal of the Michigan State Medical Society:*

"The House of Delegates adopted with little comment the following resolution:

" 'The House of Delegates shall postpone action on health insurance, continue the Committee on Medical Economics and shall hold itself ready for special call, if and when, any national or state programs of health insurance appear imminent. Your committee discourages the further expenditure of funds in this work excepting regular funds of the Michigan State Medical Society, if and when, such funds may be made available by the House of Delegates.' "

In the opinion of some members of the medical profession who have given much thoughtful consideration to the question of health insurance and its many ramifications, the Michigan House of Delegates acted wisely in postponing action on the plan suggested for inauguration in that state.

Little, if any, unfavorable criticism has been voiced of the intent and motives underlying the study of the question of medical economics conducted by the Michigan society.

Michigan has been seeking information and studying conditions. It has assembled valuable data and opinions on a major question confronting the medical profession. It deserves credit for its initiative and, at the same time, its wisdom in refusing to take hasty and inadvisable action, especially at this time.

— OSMJ —

Some Don'ts

In his President's Page comments in this issue of *The Journal*, Dr. Caldwell presents some very definite and convincing reasons why it is more vital now than ever before for the maintenance of strong and aggressive organization machinery on the part of the medical profession and summarizes some of the distinct benefits accruing from membership in organized medicine.

Reading of his remarks on the subject may cause some members to recall the pertinent observations made some years ago by the editor of the *Illinois Medical Journal* under the title, "How to Kill A Medical Society".

These have been widely published in medical journals since their original appearance and they may be slightly shop-worn, as it were. However, they are just as timely and apropos today as when written, so with apologies to those who may have read them before, they are repeated for the sake of emphasizing how a member should *not* conduct himself:

1. Don't come to the meetings. If you do come, come late.
2. If the weather doesn't suit you, don't think of coming.
3. If you do attend a meeting, find fault with the work of the officers and other members.
4. Never accept office, as it is easier to criticize than to do things. Nevertheless get sore if you are not appointed to a committee; but if you are, do not attend the committee meetings.
5. If asked by the chairman to give your opinion regarding some important matter, tell him you have nothing to say.
6. After the meeting, tell everyone how things ought to be done.
7. Do nothing more than is absolutely necessary, but when other members roll up their sleeves and willingly and unselfishly use their ability to help matters along, howl that the organization is being run by a clique.
8. Hold back your dues as long as possible; or don't pay at all.
9. Don't bother about getting new members; let George do it.

ACUTE EMPYEMA
COMPARISON OF RESULTS IN CHILDREN AND ADULTS

By CARL R. STEINKE, M.D., F.A.C.S.,

Akron, Ohio

IN articles upon empyema, very little comparison has been made between the condition in children and adults. In this paper the 138 adult cases reported are from the City Hospital of Akron, while most of the 329 children (those under 16 years of age) are from the Children's Hospital and a few from the City and St. Thomas Hospitals.*

Males outnumber females 3 to 1 in the series of adult cases (103 of the cases in men and 35 in women), while in children it was 3 males to 2 females (198 males and 132 females).

The side involved was: right 54 per cent, left 46 per cent, with one case of bilateral empyema in the adults; 3 per cent bilateral, 5 per cent not stated which side, 44 per cent right, and 48 per cent left in the children.

In Table I are listed the conditions predisposing to the disease. It will be noted that pneumonia played an overwhelming role in the predisposition to empyema. Eighty-seven (63 per cent) of the adults had histories of predisposing pneumonia and 13 (9.4 per cent) additional cases began with pain in chest and cough which was probably pneumonia. Of the children there were 209 cases (63.5 per cent) having had pneumonia and an additional 9.7 per cent had symptoms of pain in the chest, cough, etc., making practically the same proportion as in the adults.

TABLE I. COMPARISON OF PREDISPOSING DISEASES IN ADULTS AND CHILDREN.

	No. of Cases		% of Total		Total	
	Child.	Adult	Child.	Adult	No.	%
Pneumonia	209	87	63.5	63.0	296	63.4
Pain, cough, etc. (Likely pneumonia)	32	13	9.7	9.4	45	9.6
Influenza	7	4	2.1	3.0	11	2.4
Pleurisy	5	2	1.5	1.5	7	1.5
Other causes	76	32	32.2	23.1	108	23.1
Total	329	138	100.0	100.0	467	100.0

Ochsner and Gage[4] found pneumonia the predisposing cause of empyema in 61.6 per cent of their 124 cases. Eighteen and one-tenth per cent of the cases had had influenza and 12.8 per cent were tuberculous. Locke[5] in his series of 478 cases from the Boston City Hospital found 245 (52 per cent) secondary to lobar pneumonia, and 43 (9 per cent) following bronchopneumonia.

Binney[6] found that empyema followed lobar pneumonia in 66 of 100 cases. He found a decreasing mortality with the length of pneumonic process or of the period after recovery from pneumonia, a finding in agreement with other writers.

The first 50 cases reported in this series of empyemas in adults entered the hospital during the year 1920 showing a high incidence that year. In every instance in which the predisposing disease was recorded it was given as pneumonia.

In 50 per cent of the cultures from adults, pneumococci were found, as compared to 69 per cent from the children. Staphylococci were cultured in 6.6 per cent of the adults compared to 8.6 per cent of the children. Streptococci were present in 3.3 per cent of the adult cultures in contrast to 8 per cent from the children. The reason for not obtaining more frequent positive cultures may be due to the type of media used, the delay in culturing after the operation, or in late operations the pus may be sterile.

The age range was from a few days old to 74 years. Of the 467 cases, 295 (63 per cent) occurred in the first decade showing the very high incidence of empyema during the first 10 years of life, and the mortality during this decade was 64 per cent of all the decades. The mortality for the cases occurring during the first year of life was about 70 per cent and the second year about 45 per cent. The mortality after the third year was so low it reduced the first decade mortality below the sixth and fourth decades. In Table II it will be noted that 65 deaths occurred in the first decade of life, being 90 per cent of the 72 deaths in children under 16 years of age, and although the number of cases of empyema in children is more

TABLE II. NUMBER OF CASES, DEATHS AND MORTALITY RATES ACCORDING TO DECADES; CHILDREN AND ADULTS.

Age	Number	% of Total Cases	No. of Deaths	% Mortality by Decades
0—10	295	63.2	65	22.
11—20	48	10.3	10	20.8
21—30	51	10.9	8	15.7
31—40	25	5.4	6	24.
41—50	19	4.0	3	15.8
51—60	12	2.6	3	25.
61—70	2	0.4	0	0
71—80	1	0.2	0	0
Not given (adults)	14	3.0	7	50
Total	467	100.0	102	21.8

Read before the Surgical Section, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

* A report of 310 cases of acute empyema in children will be published in January, 1935, issue of The Annals of Surgery.

than twice that of the disease in adults, these figures may be compared since these two groups cover all the cases of acute empyema during the same period of years from the Children's Hospital and the City Hospital of Akron (the latter comprising practically all adults).

Ninety-six of the adults improved following operation, 12 were classed as cured and 30 (21.7 per cent) died; of the children 193 were improved, 61 cured and 72 (21.9 per cent) died; the total mortality was 21.8 per cent. Improved included those clinically cured but the wound was not completely healed on discharge from the hospital. It should be emphasized that empyema practically always occurs as a complication to pneumonia or some other disease and is rarely, if ever, a primary disease.

There is a difference of opinion with different writers as to the type of operation deemed best to use. Makel[1] uses aspiration to relieve cardiac and respiratory embarrassment when hemolytic streptococcus is the causative organism, until frank pus appears, then uses the closed method. When empyema is due to pneumococci and other organisms that are frank pus producers, the closed method is used. When empyema is due to the tubercle bacilli, repeated aspirations are used to relieve cardiac and respiratory embarrassment, but if a mixed infection occurs, the closed method is necessary.

Reporting the surgical treatment in cases of acute empyema at the Walter Reed Hospital, Makel found that where the delayed operation with the closed method of treatment was used, at the end of 10 years 92 per cent of the cases responded, 4 per cent needed further operative treatment and 4 per cent died.

Williams[2] reporting 139 cases of empyema from the Melbourne Hospital during 1919-1924 wrote that rib resection was done in all but one case. His mortality was 16 per cent.

Foster[3] in 153 cases from the New Haven Hospital treated from 1919-1929 reported 15 fatalities (9.8 per cent). The treatment used was delayed costectomy and constant suction tube drainage.

Ochsner and Gage[4] in a series of 124 cases used rib resection in 53 instances (39.2 per cent) with a mortality of 13.2 per cent. Aspiration alone was used in 12 cases (8.8 per cent) and aspiration with air replacement in 29 (21.5 per cent). Intercostal drainage was used in 41 cases (30.3 per cent). The best immediate results—a mortality rate of 10.3 per cent)—were obtained by aspiration of the pleural contents followed by air replacement. The highest percentage of good late results, that is, those recovering and improved, was obtained by intercostal drainage (87.7 per cent), while in aspiration and air replacement it was 79.2 per cent. In other words, the immediate low mortality figures do not mean the best end results in a given group of cases.

TABLE III. COMPARISON OF RESULTS OF VARIOUS TYPES OF OPERATION IN ADULTS AND CHILDREN.

Operation	Total cases		Deaths		Combined cases	Combined deaths	Mortality %		
	Child.	Adult	Child.	Adult			Child.	Adult	Total
Resection	271	118	32	21	389	53	11.8	17.7	13.64
Intercostal drainage	5	4	2	1	9	3	40.	25.	33.3
Thoracentesis	24	9	11	4	33	15	45.8	44.4	45.45
Drainage	3	0	1	0	3	1	33.3	0	33.3
None	25	2	25	2	27	27	100.	100.	100.
Not stated	1	5	1	2	6	3	100.	40.	50.
Total	329	138	72	30	467	102	21.9	21.7	21.8

In this series, rib resection was the operation of choice, being used in 118 (85.5 per cent) of the 138 adult cases and in 271 (82.4 per cent) of the 329 children. In Table III is shown the number of cases and the mortality figures in the various types of operation for adults compared with that of children, and the whole totaled. It will be noted that the mortality from rib resection in children was 11.8 per cent as compared with 17.7 per cent in adults. This is noteworthy, for many authors feel that the danger of rib resection in children is marked, and advise it only for adults. The mortality from thoracentesis alone was 45.8 per cent for children and 44.4 per cent for adults. However, as there were only six cases in adults and 23 in children, definite conclusions can not be drawn. There were 27 cases not operated at all with 100 per cent mortality.

In this series of cases there were several which deserve special mention. One case whose empyema was secondary to pneumonia, died following resection of the ninth rib. Autopsy revealed multiple empyema cavities, a serofibrinous pericarditis, passive congestion and acute degenerating changes of liver and kidneys.

Another patient who had two rib resections in the course of three weeks died. At autopsy there was found gangrene and multiple abscesses of the right lung, tuberculous pneumonia of the upper left lung and purulent bronchitis.

Another autopsy revealed toxic myocarditis, hepatitis and nephritis in addition to a chronic adhesive peritionitis.

These findings confirm the observations of others that generally patients do not die of simple empyema, but from complications.

The average number of days in the hospital was approximately 35 for adults and 25 for children. The shorter time in children is likely due to their more rapid healing power when they do recover and earlier complications with more rapid death if they die.

CONCLUSIONS

1. The very high percentage of deaths from empyema in the first two years of life is due, no doubt, to the type of infection (most of the cases follow broncho-pneumonia), the low resistance of the patient during that early period of life and

the great number of complications from spread of the infection.

2. The proportion of adult males having empyema is considerably higher than in children.

3. Pneumonia is by far the most frequent predisposing factor.

4. The lowest mortality by far was following rib resection.

5. The average number of days in the hospital was considerably lower in children.

6. Most deaths occur from complications and not from empyema itself.

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DISCUSSION

D. W. PALMER, M.D., Cincinnati, Ohio: One is lucky to be able to report but 3.3 per cent in adults and 8 per cent in children of streptococcus empyema. I have always felt that the prognosis of streptococcus empyema corresponded quite well with that of streptococcus peritonitis, the two cavities having similar absorptive powers. The fact that the percentage of streptococcus infections in children was almost triple that of adults is certainly a big factor in the child's death rate. Further facts undoubtedly are: a lack of immunity to infections in early years; a lack of rigidity of the mediastinum so that it is not a stable wall thus adding to the respiratory and circulatory load of the sick child. Late diagnoses are much more common in the child than in the adult and a lessened vital capacity in children further increases the mortality. The death rate of empyema complicating broncho-pneumonia runs much higher, perhaps three times, that of lobar pneumonia. The broncho-pneumonia association with infectious diseases of childhood therefore, increases the mortality rate of children.

We can not too strongly emphasize the fact that a patient seldom dies of empyema. Such cases that come to autopsy show more than enough else wrong to be an ample cause of the death. Brain abscesses, meningitis, peritonitis, pericarditis, myocarditis, acute nephritic conditions, all are sufficient explanations for a fatal end result and they represent, as does the empyema, a complication of the original infection which in approximately three-fourths of the cases is lobar or broncho-pneumonia. Therefore, we must appreciate that a patient dies of the original infection, or distant complications, not its local complication of empyema, unless, one is misled into a too early operation on the empyema. Too early operation for empyema is no more to be considered than operation of an early finger infection. Practically all pneumonias have some pleural serum exudate with pus cells and bacteria in the effusion. Surgery on such early cases is unsafe and unnecessary surgery. Many World War empyema deaths were deaths from operation in the early period of empyema development.

During this waiting period of empyema development, three things may be accomplished by nature. First, the development of an immunity to the infection; second, stabilization of the mediastinum by pleural induration and adhesions; third, beginning improvement in the primary disease. During this period, aspiration under rigid aseptic technique may be valuable in making a diagnosis, determining progress, or by removing pressure in the presence of excessive exudate thus limiting absorption. A surgical procedure directed at the relief of empyema should not be made until there is frank pus and a real abscess has developed. Then in my opinion, as well as others, the process should be treated as any other abscess and free drainage accomplished by some type of open operation and rib resection. This drainage should be free and wide as if it is made at the proper time, danger of complications will be greatly lessened.

— OSMJ —

Care of the Umbilical Cord in the New-Born

By REED O. BRIGHAM, M.S., Ph.D., M.D.,
TOLEDO, OHIO

THE emphasis of obstetrics today is concentrated in the better care of both the mother and the infant. In this article, the author wishes to review some past experiences in the treatment of the umbilical cord, and to make some suggestions for improvement.

The usual method of treating the cord is to tie with tape about one inch from the body and then ligate. If a tape is not available, string for tying the cord is used. This method has been used for generations and in most cases is satisfactory. Some prefer a double tie to be sure there will be no hemorrhage. The time required for the cord to disintegrate and come off is usually seven to ten days and sometimes longer, and the odor often becomes objectionable. There are disadvantages in this method.

The author found while traveling in Africa that the natives there do not tie the cord. They simply crush it and tear it off, and then place a piece of burnt corn husk or burnt rag over the cord. The majority of cases do well, but occasionally there are severe hemorrhages, sometimes resulting in death.

Various clamps have been devised for the purpose of ligating the cord. Some of them are likely to slip off and result in a hemorrhage. The Ziegler clamp has certain advantages, but it is rather difficult of application and expensive. Dr. W. H. Taylor of Omaha, Nebraska, informed the author during a visit at his clinic that he uses short hemostat which, in his hospital practice, he finds to be very satisfactory and he also uses it in the home. He removes the hemostat in 24 hours and has no hemorrhage. He applies this hemostat the same as clamps, close to the body of the infant. There is some objection to using this in the home, because in handling the infant by untrained hands some damage may be done. The advantage of using clamps is that the cord is immediately dehydrated, dries quickly, and

usually drops off in two to three days. There is also less danger of infection which certainly is of great advantage if one has ever experienced a streptococcus infection of the umbilicus. The clamps may be sterilized and are cleaner and hold less chance of infection than does a cord.

The writer has devised a clamp consisting of a piece of aluminum, three-eighths of an inch wide and two and one-fourth inches in length, and this is easily bent into a U-shape and applied over the cord by the aid of forceps. It has the advantage of being as easy of application as tying. It firmly compresses the cord and in using them for over five years, he has not had an unsuccessful case. They are especially advantageous in friable cords that may be cut by tape.

These clamps may be made up by any metal worker and the cost is practically nothing. They are even cheaper than tape and the efficiency is far superior. There is no danger of their coming off and they are light in weight.

1320 MONROE STREET.

TUBERCULOSIS AMONG RURAL CHILDREN IN LORAIN COUNTY

By H. R. O'BRIEN, M.D.,

OBERLIN, OHIO

TUBERCULOSIS in children manifests itself in several main forms. A generation ago we thought first of the bones and joints, but today we find the tracheo-bronchial lymph nodes most frequently invaded. In some children the parenchyma of the lung is involved, and the disease progresses along the same lines as in adults. Occasionally cervical adenitis is seen, or peritonitis, or terminal meningitis.

The disease is not inherited. It is communicated from person to person. Today we appreciate that most of it comes, not from dust or restaurant food, or people met in a street car, but from active cases in the child's environment. Tuberculosis is curable; the earlier it is found the more easily it is cured.

How can we find these early cases? Just how much tuberculosis is there? Where is it the worst?

These questions Lorain County set out to answer last winter and spring. Local resources already included: organized health departments in the county and in Elyria and Lorain, the tuberculosis sanatorium at Amherst, regular chest conferences in the cities, an active Christmas Seal organization, and work in skin testing already started. The C.W.A. approved a project for supplying extra nurses and clerks for a tuberculosis survey. This survey finally covered all of the county, but it is with the rural districts that this paper is especially concerned.

The general health district of Lorain County, of which I was then health commissioner, covers some 476 square miles, in which 41,000 people reside. There are 20 townships and 11 villages, the largest of which, Oberlin, has a population of 4,200. The people are an average mixture of American and European stocks. There are some 1,400 negroes, grouped largely in Oberlin. The main occupations are farming, dairying, truck gardening, small town business. It is a rural area, but adjoining the industrial cities of Elyria, Lorain, and Cleveland. The surface is rolling, sloping gradually to Lake Erie.

Plans for the survey were drawn up in consultation with the doctors at Amherst, the first village covered. These plans were then brought before the County Medical Society, where they were approved. The nurses visited first all of the families then on the tuberculosis lists of the health department. Some of the cases had not seen their doctors recently. Many of the contacts had not been examined. From these families the work led to a general offering of examinations among the school children.

Ordinary methods of physical examination by percussion and auscultation are not sufficient to diagnose tuberculosis in children early enough to be of value. We must rely on the *X*-ray to tell us what is beginning to happen in the lungs. The machinery for group *X*-rays has been greatly simplified in Lorain County. A flat plate was taken instead of a stereogram. Those who were able paid a special rate of $2.50 to the hospital or sanatorium. For others the sanatorium took *X*-rays without charge, the County Tuberculosis and Health Association supplying the films.

We did not have the resources for unlimited *X*-rays. To find out those for whom *X*-rays were really necessary the skin test was used as a filter. The more sensitive Mantoux procedure was followed, using tuberculin secured from Saranac Lake and diluted in our own laboratory. A dose of 0.1 mg. of Old Tuberculin was injected intradermally. The reaction was read in 48 hours, and

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graded according to the standards of the National Tuberculosis Association. The reading was reported to the family physician, and he was interviewed before approaching positive reactors for an *X*-ray. In all, 2,426 children of 19 or under were tested in the general district.

There is a popular feeling, shared by most of us physicians, that underweight children are more liable to be tuberculous, and that any case finding effort should therefore concentrate on the underweight. The figures of this survey were especially examined with this in mind. The grade school children had been weighed in the fall of 1933 and classified as 10 per cent or more underweight for their age and height, as normal in weight, or as 20 per cent or more overweight. Of these children later tested, out of 159 reactors 19 per cent were underweight, while of 1,149 negative children 20 per cent were underweight. Five of the positives were even overweight. The figures were examined in another way. The average weight was calculated for each positive or negative group, in each sex and year of age, from 6 to 14. Of the nine age groups among the males, the positives averaged heavier than the negatives in six; among the females the positives averaged more than the negatives in seven of the nine ages. It is true, of course, that tuberculosis once started in an underweight child will tend to develop more rapidly than in a normal individual. Loss of weight may also lead us to suspect tuberculosis in an individual child. Yet in making a search for early cases we must always include children apparently normal.

The percentage of reactors naturally increases with age. Children growing up are in contact with more people and over longer periods of time. In this district 5.9 per cent of the 0-4 year groups were positive, 10.5 per cent of the 5-9 year olds, 16.2 per cent of the 10-14, 27.3 per cent of the 15-19. The same sort of curve was found in each school district save in Amherst.

For the district as a whole 16.4 per cent of those under 20 were reactors. This corresponded with 16 per cent found in Cattaraugus Co., New York. It contrasts with 28 per cent for Massachusetts school children, and with 70-80 per cent in some eastern cities. I wish to emphasize this point again. Every once in a while we hear: "What is the use of the skin test anyway; everybody is positive." In Lorain County that is far from being the case—5/6 of the children were negative. Even among the 85 tested who were 20 years of age or older, only 30.6 per cent were positive.

A positive Mantoux Test means the presence of living tubercle bacilli in the body. We are asked: "Is the size of the reaction an indication of the activity of the tuberculous process?" To answer this the *X*-ray readings were classified. The accompanying table shows there is no correlation; two with "one plus" proved moderately advanced pulmonary form while five "three pluses" were healed hilus cases.

ACTIVITY OF TUBERCULOUS PROCESS IN POSITIVE MANTOUX REACTORS

Reaction	Childhood Tuberculosis		Pulmonary Tuberculosis				
	Healed	Active	Minimal	Mod. Adv.	Indefinite	Healed	Total
0	1	0	1				2
1	30	36	27	2	4	3	102
2	41	24	25	1	3	1	95
3	16	24	16	2	0	1	59
4	0	2	0	1	1	0	4
	88	86	69	6	8	5	262

The heaviest Mantoux rate was found in South Amherst, where 57.5 per cent of the high school group were positive. Large sandstone quarries are located here, but many reactors had no family connection with the quarries. North Amherst has quarrymen and cutstone workers also, and many deaths, but a lower Mantoux rate. Oberlin showed a high percentage of reactors. This cannot be ascribed to the negroes in the schools, for the two races had the same rates. The moderately high rates in suburban Avon Lake and Columbia may reflect migration from Cleveland. Suburban Ridgeville and the village of Wellington were pleasantly low, with less than 10 per cent of the pupils reacting.

X-RAYS

A positive reaction to the Mantoux test indicates only the presence of living organisms. Whether they are active and progressing, or quiescent will be revealed in part by the *X*-ray. During this survey 276 *X*-rays were taken of these children; with rare exceptions they were read by Dr. A. H. Smith of Pleasant View Sanatorium. They were well divided between the sexes. Of the total 90, or 32.6 per cent, showed healed tuberculosis of the childhood type, while 93, or 33.6 per cent, had childhood tuberculosis which showed some activity. Of the others, 73, or 26.4 per cent, showed active pulmonary infection, though minimal in extent; six others, or 2.2 per cent, were moderately advanced. Five had healed pulmonary involvement, while nine, or 3.3 per cent, were indefinite. Expressed in terms of the 2,426 children skin tested, 3.7 per cent showed healed childhood tuberculosis, 3.8 per cent had active childhood type, and 3.3 per cent were reported to have some active pulmonary involvement.

One child of two and one of three showed active childhood tuberculosis. Two children of six and two of seven had early cases of the adult form. Two children of eight had moderately advanced cases. Of the 79 active pulmonary cases found, 31 were under twelve years of age.

There is in the county today very little bone and joint tuberculosis. This is a result of the

tuberculin testing of cattle with elimination of reactors, of sanitary education, and of pasteurization.

DEATHS

A study was made of the deaths from tuberculosis in our area in the last ten years, from 1924 to 1933. They numbered 171, 102 male and 69 female; 20 were colored. Rates for sex and age groups were calculated from the tables of the 1930 census.

The tuberculosis death rate in Ohio pursued a steadily downward course in the last ten years. The rates in this district are consistently lower than the state figures. Negro rates, while much higher, are improving even more rapidly than the white. This is all very encouraging, but as someone once said; "For the fellow who dies it is 100%".

TREATMENT

What should be done to follow up such a survey? That depends on the individual child, his conditions and his surroundings. If he has an infection, where did he get it? Is he still exposed to a further stream of infection from the same source? Finding the source and preventing further contact constitute the first and most important step. The treatment of the child himself lies with his family physician. The youngster with the healed childhood type will probably need only hygienic living with special observation at times of strain, as at adolescence. If the childhood variety is active he may need more frequent examinations and special rest. Whether he stays out of school or not depends on his condition; this type is not dangerous to other children. The treatment of the pulmonary type will again lie with the physician, who will probably consult with the specialist. Each child, to quote Dr. Kendall Emerson of the National Tuberculosis Association, is an individual problem and should be treated in that light. In Lorain County the physicians were active in directing the treatment of their cases. Some had already been admitted to the sanatorium. In some homes diets were supplemented by relief aid.

In the epidemiology of tuberculosis, two points

AVERAGE WEIGHTS OF POSITIVE AND NEGATIVE REACTORS BY SEX AND AGE GROUPS

Age		Positive Reactors			Negative Reactors			Av. Wt. of Pos. Less than of Neg.	
		No.	Total Wt.	Av. Wt.	No.	Total Wt.	Av. Wt.	M	F
6	M	6	295	49	66	3.111	47	—	
	F	7	341	48.6	71	3.161	44.5		—
7	M	8	433	54	61	3.129	51	—	
	F	7	365	52	68	3.347	49.2		—
8	M	12	657	54.8	99	5.786	58.4	-/-	
	F	11	639	58	90	5.048	56		—
9	M	10	704	70.4	103	6.658	64.6	—	
	F	8	492	61.5	94	5.904	62.8		-/-
10	M	8	590	73.7	74	5.257	71	—	
	F	15	1.037	69	98	6610	67.4		—
11	M	17	1.280	75.3	65	4.975	76.5	-/-	
	F	14	1111	79.4	80	6230	77.8		—
12	M	12	1.058	88.1	56	4.596	82	—	
	F	6	527	88	64	5739	89.6		-/-
13	M	8	769	96	23	2.142	93	—	
	F	3	349	116	18	1637	90.9		—
14	M	4	556	89	10	930	93	-/-	
	F	2	201	100	7	625	89.3		—
Total	M	85			557				
	F	73			590				
		158			1,147				

In general we find the pattern usually observed. The dangerous periods in childhood are infancy (from one to four) and adolescence. The disease is more fatal to the adolescent girl than to her brother. Among adults the rates for young women and middle aged men are especially high.

In Oberlin during this period the colored death rate was over four times that among the white race. The school tests showed no difference in infection rates. Evidently here, as elsewhere, the negro is no more prone than his white neighbor to contract tuberculosis, but once it is contracted, he is particularly susceptible. Part of this is race; part is probably also poor housing and malnutrition.

DEATH RATES FROM TUBERCULOSIS, 1924-33
BY AGE AND SEX GROUPS

Age	Deaths per 100,000 Total	Male	Female	Age	Deaths per 100,000 Total	Male	Female
Under 1	0	00	00	30-34	45	49	41
1—4	21	31	12	35-44	48	51	46
5—9	3	5	0	45-54	77	107	45
10—14	3	5	0	55-64	69	94	21
15—19	19	10	29	65-74	68	74	61
20—24	45	26	67	75	77	137	21
25—29	109	116	101	Total	44	51	37

stand out. If there is an active pulmonary case, whom has he infected? A search of his contacts should be begun at once, especially among the children. If through some survey or other examination a child is found infected, from whom did he get it? Investigation of the child's environment may reveal a hidden case infecting an unsuspecting circle. Such investigation is a duty of the health officer, but the practitioner has the opportunity and the privilege of doing such satisfactory and important detective work himself.

The community should attack the problem indirectly and in the mass. They will use such means as adequate medical inspection of school children, improved school nursing, instruction in nutrition, hot lunches, and "wider use of modern methods of teaching hygiene and health habits to children".*

SUMMARY

Through special effort Lorain County appraised its tuberculosis problem. Of 2,426 children tested by the Mantoux method 16.4 per cent were shown to be infected. X-rays revealed that 3.8 per cent had childhood tuberculosis of some activity, and 3.3 per cent some active pulmonary involvement. The age and district centers of heaviest infection were located. The public received intensive health education in this field. By continuous cooperation of parents, physician, school, health department, sanatorium, and sometimes of relief authorities, progress can be continued. Other areas can do the same. It is a matter of education and cooperation.

DISCUSSION

H. G. SOUTHARD, M.D., Columbus: The pertinent topics in Dr. O'Brien's paper which seem worthy of discussion, are: (1) Method of Survey, (2) Results from Survey, (3) The question of the use of paper films in county surveys.

Method of Survey—

Dr. O'Brien has used two methods of approach to the problem of a Tuberculosis Survey in his county. In one group, comprising the villages of Amherst, South Amherst, Wellington, Ridgeville, Avon Lake and Oberlin he has apparently tested all of the children in the school.

In Elyria, Dr. French modified this somewhat by testing all of the children in the Junior and Senior High Schools, but did very little work among the lower grades.

In the second group, working in the City of Lorain, Dr. Adair tested only contacts and underweight children.

Dr. O'Brien in his published survey has not stated his opinion as to the relative merits of these two methods.

This is an important question in preventive medicine, and has been the subject of considerable investigation and controversy.

Chadwick, working in Massachusetts in 1926, was one of the first to make an extensive and comprehensive survey with the tuberculin test. He used the Von Pirquet Test on over 26,000 children. (It has since been demonstrated that the Mantoux Test is more reliable and is in general use at the present time.)

Dr. J. H. Korns, writing in the American Review of Tuberculosis (August, 1933) raises several objections to this wholesale method of testing. He bases his objections on the following facts:

(1) Bovine tuberculosis has been practically eliminated, so that we are dealing mainly with human contact.

(2) Present day methods are detecting adult cases earlier than previously, and are locating the sources of contact.

(3) With the wholesale school examination, the preschool children are missed.

(4) Less than 50 per cent of the school children can obtain permission from their parents to be tested—thus allowing a loop hole for many missed cases. This was true in Dr. O'Brien's work, I believe.

(5) The wholesale method is time-consuming.

(6) The tests, if negative, should be repeated annually or bi-annually if one is to safeguard the individual completely, or to know the epidemiology of tuberculosis in the community.

(7) A negative test may give the parents a false sense of security.

Korns concludes that more tuberculous infection and disease were found by examining contacts of diagnosed cases, than by examining routinely apparently healthy school children.

He also states that tuberculin testing of High School students is desirable in the hope that by *X*-raying the reactors adult lesions may be discovered.

McPhedran, at the Henry Phipps Institute in Philadelphia, has used both methods, and concludes that the contact method is economically the easiest to justify. In a well controlled survey he found that in families with a sputum positive member, 80 per cent of the children had positive tuberculins. In families with no sputum positive member, only 20 per cent of the preschool children had positive tuberculins. (It will be noted that this survey was carried on in a thickly populated city.)

There has recently come to our attention another method of survey—for example, the use of paper films in a wholesale examination of school children. I believe that the State Department of Health in Connecticut is using such a program.

(For a county or state-wide survey I believe the contact method is the one of choice at the present time, with limited personnel and limited funds.)

Results of Survey

Several interesting facts are again brought out in Dr. O'Brien's survey. Nutritional status and tuberculosis in children have no relation, whatever. Unless a child has a positive tuberculin, or is in contact with a known case, he cannot be said to be in a pre-tuberculous state, no matter how poor his nutritional state may be.

It is also well brought out in his survey that the degree of reaction to tuberculin is in no way proportional to the degree of pulmonary involvement.

McPhedran, however, has pointed out that in using 0.01 mgms. of Old Tuberculin, he found in the one-plus reactors 38 per cent had positive *X*-ray findings, while in the three-plus reactors 66 per cent had positive *X*-ray findings.

The downward trend in death rates brought out in his survey point to the improved care in

*The Tuberculosis Problem in New York State.

our sanatoria, and to the early diagnoses that are made by our physicians.

One of the Age Groups where tuberculosis causes the greatest disaster is *15 to 20*. Lawrason Brown, of Saranac, believes that every High School student deserves a chest plate before leaving school.

The interesting data on Amherst Township can best be explained by the fact that they are dealing with an industrial group, and possibly a shifting population. His parentage of reactors is high only in comparison with the surrounding territory. Drolet in his recent New York City Survey of 8,045 children, [American Review of Tuberculosis, July, 1934] found the following:

Age— 0 to 5 years..... 9.2 per cent positive
Age— 6 to 10 years.....18.1 per cent positive
Age—10 to 15 years.....31.4 per cent positive

The fact that Dr. Hayhurst has carefully checked the quarry workers and found a low incidence of tuberculosis, would tend to throw considerable doubt on the high death rate from tuberculosis in the older age group among the men. Many of these cases may have been Silicosis.

Another interesting feature was the high percentage of positive reactors with positive *X*-ray findings. McPhedran in a carefully studied survey of 467 reactors found only 14 per cent with just enlarged hilus glands; 2.1 per cent with latent parenchymal infiltration and enlarged glands; and only 0.6 per cent with manifest tuberculosis.

This great difference in figures may be largely a matter of *X*-ray interpretation. McPhedran used sterescopic films, and also oblique exposures.

Paper Films

As mentioned previously, paper films have been used recently in several surveys. Barnard, in writing in the American Review of Tuberculosis (June, 1932) states that the cost is about one-half that of celluloid films. She states that the paper films lose some of the finer detail, but proved satisfactory in an industrial survey.

The favorable aspects of this method appear to be:

(1) Lower cost. However, one must not forget that a longer exposure is required, thus diminishing the life of the *X*-ray tube by that much.

(2) More children can be examined in a much shorter time.

The main objection is the loss of fine detail essential in picking up early cases.

It is suggested that in follow-up work, where the first film has been a celluloid film, that this method might prove satisfactory.

There has recently come to this office information concerning Tuberculin Tablets P.P.D. (Parke-Davis Company), which are said to be sponsored by the Research Division of the National Tuberculosis Association.

It has been known for some time that the tuberculin reaction is an allergic response to the tuberculin-protein, and this product is said to be the precipitated protein fraction of tuberculin.

In a recent report (American Review of Tuberculosis, August, 1934) Lichtenstein, in Chicago, found the tuberculo-protein fraction reliable, easily standardized and lacking the many extraneous materials present in Old Tuberculin.

Before using Tuberculin Tablets P. P. D. in a county or statewide survey, it would seem wise to put this particular product to a clinical test, as Dr. Yochem, of Newark, has planned. Old Tuberculin is still a reliable product, and should not be discarded too hastily.

Year	*Number Cases*	*Number Deaths*
1931	5,369	4,287
1932	5,498	3,773
1933	5,274	3,744

Number Sanatoria

16— 1	State	(Mt. Vernon)
1	City	(Cleveland)
14	County	

Number Beds

1	State	250 Beds
1	City	461 Beds
11	County	1,919 Beds
3	District	289 Beds
3	Private	236 Beds

ARTHRITIS

By T. E. NEWELL, M.D.,

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THE clinician's interest in arthritis centers about two main classifications: first, the age group into which the patient falls, and second, the clinical-pathological picture of the disease. The approach to the study of arthritis on the basis of age-grouping is by all means the most practical. The pediatrician never sees hypertrophic or senile arthritis unless he visits the old folks back on the farm, or if he himself has reached the point where his spine warns him of approaching changes in weather.

Let us arbitrarily divide arthritics into three age groups: from *birth to twenty*, *twenty to forty*, and from *forty thereafter*.

TABLE A

Birth to 20 Years	*20 Years to 40 Years*	*40 Years and Thereafter*
Still's Disease	Atrophic Arthritis	Hypertrophic Arthritis
Tuberculous joints	(Focal Infectious)	
Osteomyelitis	(Local Infectious)	
Acute rheumatic fever		
Infectious Arthritis		
Gonococcal Arthritis		

In the first age group there are many bizarre arthropathies concerning which any detailed dis-

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cussion would necessarily become encyclopedic. This type of discussion I wish to avoid because all but a very few of these cases ultimately reach the specialist.

In the *first arthritic age group* we might mention Still's Disease, tuberculous joints, and osteomyelitis masquerading as arthritis. But with this mention we pass at once to the main problem. Certainly no syndrome with arthritis as its presenting feature can be more far reaching in its devastating effects than *acute rheumatic fever*. A discussion of this disease entity is not within the scope of this paper, but one cannot over-emphasize the absolute necessity of a constantly high index of suspicion for this malady when the physician is confronted by joint complaint in the young. Here one can definitely say that the proper management of an arthritic prolongs life.

Infectious arthritis enters into diagnostic consideration as this first age period advances, but as it offers no consideration peculiar to this group it will properly be discussed later. Gonococcal arthritis presenting the well-recognized, oft-quoted picture of "knee in man, wrist in woman," with the positive history or laboratory aid in diagnosis, is a suitable bridge for entering the second age period, twenty to forty. It is this *second age period* in which the greatest proportion of arthritis in all its manifestations will fall, and we shall discuss a few points in diagnostic and therapeutic management.

The *infectious* type, often called rheumatoid and now officially termed *atrophic*, is as old as history. Its etiology is conceded to be some type of infection. Some observers favor a hemolytic streptococcus, either on the basis of blood cultures, or serological reactions, principally the precipitins and agglutinins. This type of arthritis begins with pain locally, and frequently is associated with a definite story of upper respiratory infection, tonsillitis, or sinusitis. Later the joints, commonly the small ones of the hand, develop the characteristic fusiform shape without much evidence of active inflammation. In time many joints may become affected; the progress is centripetal and the distribution shows bilateral symmetry. Muscular wasting may be extreme, particularly the small muscles of the hands. In advanced stages, stiffness, contractures, especially ulnar deviation, and ankylosis are prominent. The patient's general health declines, and such symptoms as anemia, tachycardia, sweating and coldness of the extremities are noted; perhaps also enlargement of neighboring lymph glands. The heart, except for myocardial deficiency, is not directly affected. In the end stage we find the pitiable condition of arthritis deformans.

Mention might be made here of the contrast between *focal infectious arthritis* and *local infectious arthritis*. Local infectious arthritis includes the frank pyarthroses, a condition which is generally in the province of the surgeon. In focal infectious arthritis the patient is unaware of disease elsewhere in the body as the source of the joint disease. We have all seen the knee that has flared up following the removal of the periapically abscessed tooth, fortunately to subside promptly, and later to become a thoroughly useful joint.

In the latter days of this second age period, as time begins to score its points, the first creaks of hypertrophic arthritis begin to be felt, if not heard. This to the laymen is merely "old age creeping on", but to the physician it means articular and periarticular changes associated with wear and tear, plus an x quantity which is made up of metabolic, endocrine, and functional changes, the exact proportions of which have never been accurately evaluated. There are those who believe that heredity and constitutional predisposition are important factors but in any etiological discussion of arthritis one must guard against impinging on the province of the philosopher.

In *hypertrophic arthritis* as in atrophic arthritis the first symptoms may arise in the fingers but curiously enough, it is the end phalanges which are involved. There may be tenderness upon pressure or motion and the joints may tingle or ache; there arises early a slight tenderness in the transverse diameter which progresses to a degree of deformity of which women are ashamed, although this may be the only symptom of significance. When one joint such as the knee is involved the first complaint is usually that of stiffness with or without pain on starting to walk. This may be relieved after taking a few steps but pain may persist, especially at night. As the disease progresses, thickening, adhesion and contracture of the capsule and ligaments of the joint ensues, and range of motion is restricted; soon extension is impossible and faulty body mechanics are established. *X*-rays reveal overgrowth and spiculization of bone, especially at the lateral border of the joints. It is in this variety, however, that bony ankylosis rarely takes place except in the spine, giving the familiar "poker back" picture.

One other disease producing symptoms of arthritis and which may properly introduce the third and final age period is gout. As a clinical syndrome this is now fairly well understood, and with low purine diet and local symptomatic treatment has been so controlled as to have become a clinical rarity.

The *final age period* is not today a speedy but slow dissolution toward "Sans teeth, sans eyes, sans taste, sans everything." Thanks to overzealous focus hunters it is all too frequently sans teeth, sans tonsils, sans gall bladder and sans

appendix, but with newer diagnostic knowledge, this blundering situation is being corrected.

Hypertrophic arthritis in its quantitative relationship to the *atrophic* type reverses the ratio which obtained in the preceding age period. Here, the infectious type is the rarer, but is by no means absent, and in the aged may present an even more acute process. It is not uncommon to see the types mixed in the same individual, even in the same joint.

The differential diagnosis is complicated by the ever increasing menace of metastatic malignancy, and all too frequently such a process is treated with iodides! Trophic joint changes secondary to vascular disease, chiefly arteriosclerosis, and late syphilis might also be mentioned here.

The question of allergic joint manifestation is still too controversial for prolonged discussion.

TREATMENT

A favorite subject of conversation among practitioners at medical meetings is, "What are you doing for your arthritics these days?" and the variety of the answers bespeak the failure of many therapeutic measures. There is no doubt that a high percentage of these people can be helped, but the method is a "varied attack on many fronts".

Arthritis is a systemic disease with manifestations which demand the most skillful analysis. Treatment of the arthritic must therefore begin with consideration of the subject as a whole, including the hereditary, constitutional, postural, psychic and economic factors, as well as the size, shape and configuration of the body and the anatomical and physiological relationships of the various systems and organs which constitute it. We must remember that arthritis is not primarily a disease of joints.

We have found lowered metabolic rates in many, and thyroid properly administered to such patients is useful. Constipation is one of the factors that should be promptly corrected.

Even though the many writers on arthritis may differ in other methods of treatment of the arthritic patient, they all agree on the value of physiotherapy.[1] Heat, massage and exercise constitute a triad without which few or no advanced cases can be expected to recover. This benefit comes through its tendency to restore the normal blood flow to the joints. Heat applied to an involved joint dilates the vessels, softens the tissues, permits of a larger range of motion of the part and paves the way for the application of massage. The prolonged application of heat by the induction of artificial fever is of distinct value in selected cases of infectious arthritis. Pemberton thinks that massage is one of the most useful therapeutic measures available to man. Massage should at first be applied in form of mild stroking not to the joint itself, but to the adjacent tissues, then this is increased to very active massage, being careful not to irritate the joint itself. This achieves an increased blood count at times, prevents atrophy, induces some regeneration of muscle and profoundly influences the intangible processes included under the head of general metabolism.

In the acute phase of the disease a generous amount of *rest* for body and joints is essential. Some authorities require that their patients spend at least sixteen hours in bed daily. The long use of casts has its dangers and in the chronic stage of arthritis, rest must be tempered by judicious exercise to prevent ankylosing deformities.

As regards *drugs* the salicylates are probably the safest to use. Cinchopen is shown to cause atrophy of the liver and its use should be strongly condemned. Arsenic in the form of sodium cacodylate (grains one-fourth three times a day) by mouth is thought by Pemberton to be the best drug available. The iodides are used by many and are thought very efficacious; colchicum has been used at times advantageously.

Those practitioners of medicine who, as a group, probably best understand the disease are the orthopedic surgeons and their counsel is greatly needed and desired to effect a cure or correction of the malady. Banjo splints and Balkan frames have their places in therapy.

Vaccines, oxoate-B, aspirin and other drugs have all been used with good as well as poor results.

The immediate considerations, namely foci of infection, and structural abnormalities should in every case be taken care of first. There is no one way of treating these patients. Their care is long and arduous both to the patient and the physician, and it is important to "keep up the fight".

General constitutional treatment directed at proper rest and nutrition call for conscious direction of the patient by the physician as to his diet and daily routine.[2] Dietary treatment of this disease is still in the field of speculation. Minot considers it obvious that there is no standard diet for arthritis, while White shares the opinion of many others that the use of a diet low in carbohydrate and high in vitamins in the form of cod liver oil and yeast, fresh vegetables and dairy products, is beneficial. But he admits also that at times all pet dietary restrictions should be disregarded.

In general it may be said that diets high in vitamin, adequate in protein of good biological value, adequate in mineral elements and low in carbohydrates, are the most effective.

SUMMARY

Most cases of arthritis naturally fall into three age groups. These are arbitrary divisions with inevitable overlapping. In each period certain

types of arthritis are of primary importance, and are significant in differential diagnosis and treatment. The two great types of arthritis have been emphasized. There is no panacea for arthritis. The persistence of the physician, together with intelligent application of the means at his disposal and the cheerful cooperation of the patient are the prime requisites for happy results.

In conclusion I will quote Pemberton:[3] "There is no longer justification for therapeutic skepticism among that decreasing band of observers on the fringe of the problem, who have not been at pains to inform themselves regarding it. Those who cannot or will not study the problem and are not open minded will not reap for their patients the rewards available. Neither pessimism nor single-minded zeal points the way out. The physiological problem is difficult of being grasped, and busy practitioners, not unnaturally, turn to a bottle or to a syringe as a medium of escape. Hereditary influences, structural inadequacies, faulty anatomy and physiological dysfunction of the viscera cannot be undone so easily. Modified or corrected they can be, however, by appropriate procedures and therapy based on such premises and should be successful in at least 70 per cent of all cases in any critically administered clinic."

850 NORTH BROADWAY.

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ABDOMINAL PREGNANCY

Report of a Case Two Weeks Past Term

By WAYNE BRONAUGH, M.D.,

BELPRE, OHIO

ABDOMINAL pregnancy is the extra-uterine, intraperitoneal implantation of the fertilized ovum. The condition may be primary or secondary. It is primary when the ovum, fertilized in the abdominal cavity, implants itself somewhere on the visceral or parietal peritoneum. It is secondary when the fertilized ovum originally implants itself within the tube or the uterus and later is aborted into the abdominal cavity where it fixes itself and continues in growth. The usual methods by which a tubal pregnancy reaches the abdominal cavity are: (1) By abortion from the fimbriated end, (2) through a rupture of the tube. For the ovum to travel directly from the endometrium to the abdominal cavity it must be assumed that there is some abnormal connection between the endometrial and abdominal cavities.

In that the condition is unusually rare, occurring once in about 20,000 confinements, an additional case seems worthy of report.

CASE REPORT

Mrs. L. S., a white mother, age 39, was admitted to St. Joseph Hospital at 7 a. m., September 23, 1933. Her chief complaint was pregnancy two weeks past term, associated with intermittent pains low in the abdomen and the passing of a small amount of dark non-clotted blood.

Her *past history* revealed that she had two normal children, ages 13 and 16, both pregnancies being uneventful; that her menstrual life had always been normal and that she had suffered no gynecological disturbances, serious illnesses, accidents or operations.

Her *last menstration* began December 4, 1932. Her weight then was 125 lbs. Her pregnancy progressed normally until February 4, 1933, when she developed an annoying discomfort in the lower right abdomen. At this time she had to resort to the use of laxatives for constipation. She was certain that she was pregnant.

The family physician at the time, feeling something was wrong, advised a consultation which was not obtained.

At the *fourth month* the abdomen was visibly enlarged. There were marked digestive disturbances with much tenderness throughout the lower abdomen and constipation was very stubborn. Intermittent colicky cramps appeared throughout the abdomen and she was somewhat weaker than two months previous, but still attended to most of the household duties.

As the *fifth month* approached her discomfort was much accentuated. Foetal movements were largely responsible for the increase in all her symptoms. Constipation augmented her distress and regular laxatives, which had become ineffective, were supplemented by enema from which she obtained immediate relief, but the abdominal discomfort was such that she was confined to bed half the time.

As the *pregnancy* progressed it became necessary to take laxatives each day and enemas two or three times each week. The appetite was poor the greater part of the time. Most of her abdominal discomfort was in the lower right quadrant though colicky pains were generalized. As a result of the digestive disturbances she lost weight until at the time of delivery she weighed but 95 pounds.

The expected date of her *confinement* was September 9, at which time she was indeed miserable, spending most of her time in bed. Foetal movements were very active and exceedingly painful. On September 10 all foetal movements ceased and subsequent to this she felt much better, there being a partial subsidence of all gastric symptoms. Her appetite returned slowly and within a week she was able to be up and about half the time.

From this history it is evident the *death of the foetus* occurred on September 10.

Physical examination revealed a slightly emaciated woman, pregnant at term, 39 years old, with an approximate weight of 95 lbs. Her head and neck were negative except for some bad teeth. Respiratory system was negative, the cardio-vascular system showed nothing abnormal. The blood pressure was 110 systolic, 80 diastolic. The abdomen did not look as if it contained a normally pregnant uterus. The major tumor on inspection seemed to lay too high. On palpation the foetus was lying in the transverse position, head to the right. The foetus seemed just under the palpating finger. Certainly it did not appear that there was even a very thin uterine wall between the foetus and the abdominal wall. The orbits and cranial sutures could be distinctly felt. The cranial bones could be made to slide under each other by very gentle pressure. The foetus was proved dead by the softness of its head and the absence of foetal heart sounds. No movement had been felt since September 10. The foetal back pointed Cephalad, the extremities Caudad.

Vaginal examination revealed a cervix pushed under the pubic bone and to the left. A large, boggy fixed mass was impacted in the cul-de-sac. The finger entered a soft cervix, the external os of which was dilated to about three centimeters. The finger did not pass through the internal os which was quite tight. It was assumed that the pelvic mass was the uterine body turned over to the right, this forcing the cervix to its position under the pubis and to the left. I arrived at a diagnosis of abdominal pregnancy with the uterus impacted into the pelvis by pressure of the placenta and foetus from above.

At 8 a. m. the patient *passed per vaginum*, a piece of tissue which was sent to the laboratory for an immediate examination. The report submitted by Dr. Ivan Smith, pathologist, is, in part, as follows:

"This is considered a true uterine cast. Being composed as it is of decidual cells alone without villi it is indicative of extra-uterine pregnancy."

The patient was seen by two consultants. Both were of the opinion that the pregnancy was uterine, with a transverse presentation, and that the impacted mass in the pelvis was a low uterine or cervical fibroid displacing the cervix to its position under the pubis and to the left.

The urine contained hyalin casts, two plus albumen, a few red blood cells and numerous pus cells. The blood picture was normal and the Wassermann negative.

The temperature was 100 degrees, the pulse rate 90, and these associated with the above urinary findings, led to a diagnosis of pyelitis with nephirtis.

Both consultants as well as myself felt vaginal delivery not feasible and abdominal section indicated, so after appropriate supportive therapy in the form of 1000 cc. of 5 per cent glucose by vein the abdomen was opened at 4 p. m. Spinal anesthesia was chosen because of the kidney lesions present. It worked perfect with no untoward effects.

A *muddy-green colored omentum* was spread out as an apron over the abdominal viscera being attached below to the placenta, abdominal wall and uterus. Its posterior surface was diffusely and intimately fused with a bulky amniotic sac. The foetal head protruding through a rent in the omentum was lying in the upper right quadrant. The amniotic sac had previously ruptured and absorption of most of the amniotic fluid had taken place. The foetus was easily delivered after which the posterior half of the sac was seen to be fused to the ascending and transverse colons as well as to coils of the ileum. The lower half of the anterior sac with its adhered omentum was now separated from its attachments, the uterus, the abdominal wall and placenta, ligatured and removed. The posterior wall of the sac which was inseparable from the ileum and colon was left intact.

The *placenta* presented a perplexing problem. It was one and one-half that of normal size and was impacted in the right pelvis, extending upward over the right pelvic brim to the umbilicus. Its removal was impossible because of its adherence to the right tube, broad ligament, the right pelvic and posterior parietal peritoneum and the ascending colon. Huge anastomatic vessels could be seen connecting the placenta with the ascending colon. The *uterus*, twice its normal size, occupied a position in the left pelvis having been so displaced by the placenta and foetus.

To attempt removal of this placenta was to invite a hemorrhagic death, so accordingly the cord was cut close, the placenta left in situ, and because of annoying oozing the abdomen was closed with three cigaret drains protruding from the lower angle of the incision. The patient left the table in excellent condition.

The *post-operative course* was uneventful save that on the fifth day, two days after removal of the drains, quite a large amount of bloody peritonitic fluid came from the upper angle of the incision. The drainage decreased in quantity and became purulent on the eighth day. The incision gaped for about one and one-half inches and by the sixteenth day there was a profuse discharge of light brown thick pus from which was cultured a pure growth of staphylococus aureus. The patient gained strength in spite of the fact that the pyelitis persisted during her stay in hospital which lasted 42 days. She was discharged with a urine loaded with pus, a slight temperature elevation and a freely draining abdominal wound.

By December 24, three months after operation, examination revealed a very grateful patient who had gained 25 pounds and who had no complaints other than a draining abdominal wound. The placenta which was now much softer had decreased in size to one-half its original but with pressure much pus could still be expressed from it. The uterus was of normal size and back toward the midline.

Examination May 1st, 1934, seven months post-operative revealed the placenta to be the size of a lemon and drainage to have practically ceased. The functions of the gastro-intestinal and genito-urinary systems, according to her, were perfectly normal.

Examination August 1st, 1934, ten months post-operative showed the abdomen completely healed, the placenta barely palpable and the patient doing fine.

— OSMJ —

Sneak Thief Steals Directory

Several weeks ago a sneak thief stole from the waiting room of the office of Dr. J. C. Tritch, Findlay, a 1934 edition of the American Medical Directory, on page 99 of which was stamped Dr. Tritch's name. Physicians who may be asked to purchase a directory, especially by a stranger, are requested to check the volume inasmuch as it may be the one owned by Dr. Tritch.

The President's Page

A Personal Communication to the Membership from

JOHN A. CALDWELL, M.D., *President*, Cincinnati, Ohio

An Appeal for Concerted Action

THOSE members of the Ohio State Medical Association who have kept in touch with recent trends in the social, economic, and governmental affairs of the State and Nation have noted that many plans have been proposed to modify the individualistic and competitive practice of medicine. Through *The Journal*, and otherwise, the membership has been kept informed regarding strong agitation for the establishment of an elaborate national system of governmental medicine as part of an extensive social insurance program.

The adoption or rejection of these plans wholly or in part will depend not only on public reaction but also on the attitude and action of the medical profession during the months of the immediate future.

This brings me to the major point of this personal communication and appeal to each member of our State Association.

We can not even hope to succeed in the defense of our principles and policies unless we stand together as a united, aggressive, virile organization in which each man realizes he has definite duties and responsibilities and is ready to assist in the promotion of activities that are of advantage and benefit to the profession as a whole.

It is imperative that we strengthen in every possible way our organization.

We must make possible the maintenance and operation of efficient organization machinery, which, in the final analysis, is our most effective weapon in the preservation of our independence and economic security.

We must give liberally of our time, energy, and ability to the purposes and objectives of organized medicine.

We must realize that concerted and harmonious action—team work—is more essential today than ever before.

Now is the time to build our organization to the peak of efficiency and strength.

To attain greater strength, we must have not only increased activity but increased manpower in our organization.

Realizing that 1935 promises to be a fateful year for the medical profession and that we must stand shoulder to shoulder, every member should as soon as possible renew his affiliation in medical organization for the ensuing year.

It is especially important that we enhance our strength and influence by enlisting every eligible physician in Ohio in the ranks of organized medicine.

I urge each member to pay his membership dues in his county medical society and the State Association for 1935 promptly.

Membership dues in our State Association are payable in advance before January 1st. Annual per capita dues in the State Association are five dollars ($5.00) which are included in the total dues in the academy or county society and transmitted by the secretary-treasurer of the local society or academy to the State Association headquarters.

Continuous good standing in medical organization depends on the receipt of dues in the State Association at our headquarters office *before* January 1, 1935.

By way of emphasis of the importance of membership in medical organization, let me summarize a few of the general benefits of membership in our State Association, which are, of course, in addition to those obtained through affiliation with your local society or academy.

Briefly, membership in the Ohio State Medical Association:

Is an assurance of the physician's standing in his community before the public, the law and the profession.

Helps to maintain organization machinery for the service of the members and a central clearing house of valuable and pertinent information.

Makes possible the publication of *The Ohio State Medical Journal*, a consecutive record of scientific, economic, social, legal, legislative, and governmental developments of direct interest to every physician.

Provides the means for contact with state and federal departments through which the

executive, judicial and legislative branches of government can be informed of and requested to consider the concerted medical viewpoint.

Provides the means for cooperation with other state-wide and national groups interested in common problems of public health and professional practice.

Affords protection in case of malpractice suits, a service which makes unpopular all attempts to "victimize" physicians.

Makes possible the maintenance of service bureaus and committee activities for the benefit of all.

Is a requirement for fellowship in the American Medical Association.

And, finally, affords a unanimity of effort in all endeavors, particularly against the proposals of paternalism, socialized medicine, radicalism and cultism.

In conclusion, I feel it my duty to again warn the membership at large that as individuals we will be unable to cope with the dangerous situation that now confronts us.

As an aggressive, united and well-organized group, utilizing the potential strength and influence we possess, we will be able to make a determined stand in defense of our principles and rights.

It is for that reason that I appeal to every physician in Ohio to do his part by giving his active and enthusiastic support to medical organization and the work it is doing.

Drs. McClellan, Messenger and Lummis Honored Upon Completion of Fifty Years Active Medical Practice

Three veteran well-known members of the medical profession in Ohio were honored recently by their colleagues and other friends upon their completion of 50 years of active practice.

On November 15 an informal dinner was given at the Masonic Temple, Xenia, with members of the Greene County Medical Society and business and civic leaders of that city and physician friends from a distance as guests, honoring Dr. Ben R. McClellan and Dr. H. C. Messenger, both of Xenia.

The hosts were Dr. Reyburn McClellan and Dr. H. C. Messenger, sons respectively of the honored guests.

Dr. McClellan has for many years been a leading figure in medical organization in Ohio. He served as president of the Ohio State Medical Association in 1906-1907 and chairman of the Committee on Public Policy of the State Association from 1909 to 1914. From 1907 to 1914, Dr. McClellan was a member of the National Legislative Council of the American Medical Association. In 1913, Dr. McClellan was elected a delegate from Ohio to the House of Delegates of the American Medical Association and has served continuously since then, having been re-elected as a delegate for a two-year term at the last meeting of the State Association. Since 1925 he has been a member of the State Association Committee on Medical Education and Hospitals, serving as chairman since 1926, and from 1915 to 1922 he was a member of the State Medical Board.

Dr. Messenger also has been active for many years in organized medicine. In 1906 he was a delegate from Xenia County to the Annual Meeting of the Ohio State Medical Association and since 1922 has been an alternate delegate from Ohio to the American Medical Association. He has served a number of times on important committees of the State Association. For many years Dr. Messenger was medical director of the Ohio Soldiers' and Sailors' Orphans' Home, Xenia, retiring recently.

On October 24, sixty members of the medical profession and leaders in the civic life of Middletown and surrounding communities gathered at the Elks' Temple, Middletown, to honor Dr. George D. Lummis, for the past 40 years health officer of Middletown and since its creation in 1917 a member of the Ohio Public Health Council. Dr. Lummis was not only a pioneer but one of the leaders in official public health administration in Ohio. Addresses eulogizing Dr. Lummis were made at the banquet by representatives of the professions and business groups of his home community. Dr. McClellan and Dr. Messenger were also honored guests at the dinner for Dr. Lummis.

— OSMJ —

Institute Attended by 250

Approximately 250 physicians attended the First Annual Medical Institute to be held by the University of Toledo, November 2.

Lectures on tuberculosis were given by Dr. Lawrason Brown, Saranac Lake, N. Y. and Dr. Evarts A. Graham, St. Louis, professor of surgery Washington University, School of Medicine.

At the banquet in the evening the speakers were: Dr. M. D. Haag, president of the Toledo Academy of Medicine; Dr. Howard M. Bowman, Toledo University; Dr. L. A. Brewer, president of the board of trustees of the former Toledo Medical College; Dr. E. B. Gillette, and Dr. John T. Murphy.

The institute was arranged by President Philip C. Nash, University of Toledo, Dr. Fred M. Douglass, Dr. Barney J. Hein, and Dr. John T. Murphy.

LEGISLATIVE AND ADMINISTRATIVE PROGRAM INDICATES SOCIALIZATION OF MEDICINE VITAL ISSUE DURING COMING MONTHS

Several months ago the Council of the Ohio State Medical Association in an official statement (August, 1934, issue of *The Journal*, pages 516-517) declared that "the future trend, tendency and structure of government in this country will be determined by the next Congress".

In the same statement, the Council predicted that the immediate future undoubtedly would be the most critical period in the history of American medicine.

These pronouncements were motivated by observations of governmental trends generally and by events and developments which forecast a powerful drive early in 1935 to bring about sweeping and radical changes in the present system of medical practice in this country, especially the establishment of an elaborate plan of socialized medicine, subsidized, regulated and directed by the Federal government or the governments of the respective states.

More recent developments clearly justify the opinion manifest by the Council and indicate the ensuing months will be serious ones for the future of the medical profession in America.

Included as Part of Social Security Program of National Administration

Although during recent years the movement to socialize medical practice in this country has gained increased momentum because of social unrest, economic uncertainty and changes in the relationships between government and the public, the present situation confronting the medical profession did not reach a definite focus until last June when President Roosevelt created a Committee on Economic Security and by so doing gave to the campaign for socialization of medical practice in America the greatest impetus it had ever received.

Information concerning events leading up to the appointment of this committee; relative to its personnel, its duties and objectives, its early activities, and comments on the potential changes from the standpoint of medicine and public health have been published from time to time in *The Journal;* in the April issue, pages 248-249; May issue, page 290; August issue, 518-521; November issue, page 722-723; in the proceedings of the House of Delegates of the State Association, November issue; the address of the retiring president, Dr. C. L. Cummer, published in the November issue, and in the annual report of the Committee on Public Policy, October issue.

However, for the information of all members and to emphasize the seriousness of the situation confronting the profession and medical organization, *The Journal* takes this opportunity to present a recapitulation of the events bearing on this question and summarize some of the more recent developments.

Committee Named to Recommend Social Insurance Legislation

In creating the Committee on Economic Security, President Roosevelt stated that its purpose would be te study plans and recommend legislation that will permit the agencies of government to assist in the establishment of means to provide the people with security against the hazards and vicissitudes of modern life.

More specifically the committee was instructed to formulate "a comprehensive program which will give protection to the individual from all the vicissitudes and hazards of modern life—unemployment, accident, *sickness*, *invalidity*, old age and *premature death*".

In other words, the objective of the committee as it began its study was to draft an inclusive plan of social insurance including workmen's compensation, accident, health, invalidity and unemployment insurance, old age pensions, security for farmers and agricultural workers, survivors insurance, family endowment and maternity benefits, and assistance to dependent children and families without breadwinners.

Those appointed as members of the Committee on Social Security were: Secretary of Labor Frances Perkins, Secretary of the Treasury Henry Morgenthau, Secretary of Agriculture Henry A. Wallace, Attorney General Homer S. Cummings, and Federal Relief Administrator Harry L. Hopkins.

The first act of the committee was to establish a staff and select as secretary and executive director, Edwin E. Witte, professor of economics, University of Wisconsin, and for many years a labor economist associated with the Wisconsin State Industrial Commission. For the past year and until he became secretary of the Roosevelt committee, Mr. Witte was acting director of the Unemployment Compensation Department of the Wisconsin Industrial Commission, administering that state's unemployment insurance act.

A technical board of 20 persons in the government service and research staff were appointed.

Among the studies initiated by the committee

was one on "Provisions for Meeting the Economic Risks of Illness". This particular study has been in the hands of Edgar Sydenstricker and Dr. I. S. Falk, employes of the Milbank Memorial Fund. One of the primary items on the agenda of the Milbank organization is to promote the socialization of medical service, clearly indicated in the propaganda disseminated by it during recent years. Mr. Sydenstricker, director of public health activities for the Milbank Fund, as a member of the Committee on the Costs of Medical Care, submitted an independent minority report in which he stated that neither the majority nor minority reports of that committee went far enough in their recommendations and strongly intimating a system of governmental medicine should have been the chief recommendation of the committee. Dr. Falk in several recent reports publicized by his employers left little doubt as to his position in favor of the socialization of medical service.

On November 10, President Roosevelt named an "advisory council" to counsel the Committee on Economic Security on broad general policies. This advisory group is headed by Frank P. Graham, president of the University of North Carolina, and composed of the following members:

Gerard Swope, head of the General Electric Co., New York City.

Morris E. Leeds, president, Leeds & Northrup, Philadelphia.

Sam Lewisohn, Miami Copper Co., New York.

Marion B. Folsom, Eastman Kodak Co., Rochester, N. Y.

Walter R. Teagle, head of the Standard Oil Co. of New Jersey.

William Green, president, American Federation of Labor.

George M. Harrison, grand president, Brotherhood of Railway and Steamship Clerks, Cincinnati.

Paul Scharrenberg, secretary-treasurer, California State Federation of Labor, San Francisco.

Henry Ohl, Jr., president, Wisconsin State Federation of Labor, Milwaukee.

Belle Sherwin, former president, National League of Women Voters, Washington, D. C.

Grace Abbott, University of Chicago and former chief, United States Children's Bureau, Chicago.

Raymond Moley, editor, and former assistant secretary of state, New York City.

Paul Kellog, editor, New York.

George H. Nordlin, grand trustee, Fraternal Order of Eagles, St. Paul, Minn.

George Berry, president, International Printing Pressmen Union of North America.

Josephine Roche, president, Rocky Mountain Fuel Co., Denver.

John G. Winant, governor of New Hampshire.

Louis J. Taber, master, National Grange, Cleveland.

Members of Medical Advisory Group Are Selected on Individual Basis

Little information has up to the present time been given out by the Committee on Economic Security relative to the scope of its studies in the field of medicine or its views with respect to "measures for bringing about the better administration of medical care in the lower income groups".

In fact, it was some time after its organization before the committee gave any indication that the medical profession would be given an opportunity to express its views and supply the committee with information on the question of sickness insurance.

Following the publication in *The Journal of the American Medical Association* (August 25 issue, page 609) of an editorial commenting on this fact and the forwarding to Secretary Perkins and Mr. Witte of official communications from the Board of Trustees of the A.M.A. offering information in the files of the American Medical Association and the facilities of the Association to the committee in its inquiry, the headquarters office of the A.M.A. was informed by Miss Perkins and Mr. Witte that medical advice would be sought and use made of the data in possession of the A.M.A.

Early in October, the Committee on Economic Security addressed letters to a group of physicians in various parts of the United States asking them to serve as members of a small group to cooperate as advisers with the staff of the committee on medical questions.

Dr. Walter L. Bierring, president of the American Medical Association, was among those invited to serve on this advisory committee. Presumably the invitation was addressed to Dr. Bierring as an individual and not as president of the American Medical Association.

Inquiry revealed that selection of those invited to serve on the medical advisory committee of the Committee on Economic Security had been made on an individual basis without asking for nominations from any organization but the announcement was made that the advisory group would be composed of "distinguished physicians and surgeons".

In spite of the fact, as emphasized to Mr. Witte by officials of the A.M.A., that many distinguished physicians and surgeons have never given any thought whatever to matters pertaining to medical economics, the Committee on Economic Security continued with its original plan of selecting advisory physicians from various sections of the country on an individual basis.

According to word from Washington the medical advisory committee as appointed is partially as follows:

Dr. Walter L. Bierring, Des Moines, Iowa, president of the American Medical Association.

Dr. Rexwald Brown, Santa Barbara, California, surgeon.

Dr. J. D. Bruce, Ann Arbor, Michigan, surgeon.

Dr. George W. Crile, Cleveland, Ohio, surgeon.

Dr. Harvey Cushing, New Haven, Conn., professor of neurology, Yale University Medical School.

Dr. R. B. Greenough, Boston, Mass., president, American College of Surgeons.

Dr. James A. Miller, New York City, professor of clinical medicine, Columbia University College of Physicians and Surgeons, and president of the American College of Physicians.

Dr. Thomas Parran, Jr., Albany, N. Y., commissioner of public health, State of New York.

Dr. George M. Piersol, Philadelphia, professor of medicine, Jefferson Medical College.

Dr. Stewart Roberts, Atlanta, Ga., professor of clinical medicine, Emory University School of Medicine.

A series of conferences with its advisory groups, staff members and others was held by the Committee on Economic Security at Washington, November 14, 15 and 16.

By invitation, a number of officials of the American Medical Association were in attendance to participate in the discussions pertaining to the subject of providing medical care for low income groups.

Press dispatches relative to these series of conferences stated that President Roosevelt attended the opening session and outlined his opinions regarding the administration's economic security and social legislation program, stressing the point that "recovery" must take place ahead of "reform".

The Associated Press in an article concerning the President's address said:

"The Roosevelt administration in concentrating on the job of 'getting the economic system to function' may allow certain of its vast plans for social insurance to wait until better times return.

"This became clear today as observers digested a speech the President made late yesterday to delegates of the national conference on economic security.

"In talking of the social security program to be proposed to the next Congress, the President definitely included a system of federal-state unemployment insurance to be financed by contributions.

"But of old age pensions, he said: 'I do not know whether this is the time for any federal legislation on old age security'.

"Talking of insurance against sickness, he used the phrase 'soon or later', indicating that this too may go over into the future.

" 'We cannot work miracles or solve all our problems at once', he said at another point."

A United Press dispatch reporting the proceedings of the conference said:

"The group, however, was under an apparent mandate from the President to limit its scope.

"He was on record as opposed to new general taxes to cover the cost of unemployment insurance. He was disinclined to include old age pensions and health insurance in the initial program. Both would mean sharply increased government expenditures even on a share-with-states cost basis.

"The divorce of old age pensions and other security legislation from the unemployment question runs counter to the strong views of Mayor Fiorello LaGuardia of New York, spokesman of an attitude certain to have powerful voices in the next Congress. He pleaded for an all-embracing program and urged that all state legislatures meet concurrently with Congress to enact enabling legislation."

Other sources of information intimated that even though the administration should see fit not to include sickness insurance among its legislative recommendations immediately, influential blocs would undoubtedly make a desperate effort to have such legislation considered soon by Congress and enacted as a part of a social security program.

Final Decision on Proposals to Go to Congress up to President

The report of the Committee on Economic Security is scheduled to be made to the President on or about December 1 and it is announced will not be made public until released by him.

It is understood that no hearings on sickness insurance will be held under the auspices of the Committee on Economic Security which it is presumed will base its recommendations on the data and advice submitted by its research staff and advisory group.

Of course, it is presumed if any proposal for sickness insurance is submitted to Congress, official hearings will be held by the congressional committee to which the bill is referred.

It is assumed that the President, after reviewing the report of the Committee on Economic Security, will decide whether or not plans for providing some system of sickness insurance should be included in any program of social insurance he will recommend for adoption in the next session of Congress.

Naturally, the matter of whether or not sickness insurance should be a part of the administration's social insurance program and the character and extent of such proposed legislation, if any, will depend largely and directly on the President's opinion of the report and recommendations of the Committee on Social Security and public sentiment on the question.

President and Others Informed of Views of Organized Medicine

Although it had not been requested to take an official part in the deliberations of the Committee on Economic Security or in the formulation of its report to the President, the American Medical Association, through its headquarters offices,

officials and bureaus, has been in close touch with the activities of the committee.

Considerable material on the question of sickness insurance has been submitted to the committee by the A.M.A. Several conferences between officials of the A.M.A. and Mr. Witte, executive director for the committee, have been held. Every effort has been made by officials of the A.M.A. to see that the viewpoint of organized medicine is adequately presented and that the basic principles adopted by the House of Delegates of the A.M.A. at its Cleveland meeting are given serious consideration by the committee in its deliberations.

Moreover, a number of physicians, including Ohio physicians, have expressed their views, reflecting the official policy of organized medicine in communications direct to the President, members of the Committee on Social Security and members of Congress, realizing that these are most critical times for the future of the medical profession and medical practice and that public officials should be acquainted with the profession's attitude.

These communications have expressed the belief of physicians, as members of a scientific profession, that danger lies in a program for extensive socialization of medical care, especially to those individuals able to provide this type of necessity for themselves.

The belief has been expressed, as specifically enunciated by the House of Delegates of the American Medical Association at the last annual meeting in Cleveland, that the relationship between patient and physician is so intimate, personal and confidential that no third party arrangement can be satisfactory.

Also, it has been pointed out in these communications that patients should have absolute freedom to choose their own qualified physicians to serve them and their families; that under any system of administration of medical care there should be retained not only the selection by the patient of his physician but remuneration to the physician by his patient, even though such patient may be reimbursed through an insurance system or otherwise for such obligation; and that it would be detrimental both to scientific medicine and to the public to devise any uniform fee system or inflexible standardized machinery which cannot be adjusted to meet local situations and conditions.

A number of these communications have quite properly stressed the point that much of the discussion generally on the costs of medical care fails to take into account general social and economic principles affecting the public, and that if it is possible to stimulate industry, employment and consequent circulation of money and credit, the question of medical care for most people will automatically be solved.

Some Ohio physicians in communications to the President and his advisers have pointed out the contributions the medical profession always has made, especially during the recent years of economic uncertainty and have called attention to the justice of continued recognition of medical service as a necessity and of provisions for the compensation of physicians rendering service to the needy and underprivileged.

Incidentally, the protests being made by the medical profession against excessive socialization of medicine have met with the criticism of advocates of such a plan and some members of the profession that rather than oppose governmental medicine the profession should prepare and present an alternative "plan".

Many members of the medical profession who have given this matter thoughtful consideration over a period of time are of the opinion if the medical profession were to abandon certain fundmental principles, that immediately theorists, sociologists and politicians would take advantage of such concession to subjugate the profession even further than they might do if it continues to maintain a position on general principles rather than of mere forms, formalities or "plans".

Individuals and groups known as militant proponents of socialized medicine are carrying on an active campaign in Washington and elsewhere throughout the country.

During the recent election campaign, candidates for election to Congress received propaganda advocating state medicine and soliciting support for governmental sickness insurance legislation.

Moreover, it is understood that various national organizations, including women's clubs, parent-teacher associations, welfare groups, etc., have been asked by social insurance advocates to endorse national health insurance.

Ohio Legislature May Be Asked to Enact Health Insurance Bill

Supplementing the proposed Federal legislation on sickness insurance is the activity of an organization known as the "American Association for Social Security, Inc.", which has drafted a proposed compulsory health insurance bill for introduction into the legislatures of the various states this Winter.

The president of the American Association for Social Security, Inc., is Bishop Francis J. McConnell of the Methodist Episcopal Church. Abraham Epstein, long a staunch advocate of social insurance, is executive secretary. Among its vice presidents are Miss Jane Addams, Alfred I. DuPont, Glenn Frank, John A. Lapp, I. M. Rubinow and Herbert S. Bigelow. The names of Dr. Haven Emerson, New York, and Dr. Alice Hamilton, Boston, appear on the list of names of members of the organization's advisory committee on social insurance, as well as that of Mr. Witte, executive director of the Roosevelt Committee on Economic Security.

A tentative draft of the health insurance bill which the American Association for Social Security, Inc., is planning to syndicate to the respective state legislatures was discussed at a conference held a month ago in New York City and attended by a small group of physicians, dentists, hospital officials and others.

Among the provisions of the preliminary draft of the proposal is the establishment of a state health insurance commission and a state health insurance fund, to be raised by 1½ per cent of employers' payrolls, 3 per cent of the wages of employes deducted by employers and transmitted to the state fund, and an appropriation by the state equal to 1½ per cent of the total payroll of employers.

The proposal would combine cash benefits with medical, hospital, dental and maternity benefits. Its terms are so general and broad that local "councils" of the state health insurance commission could provide hospitals, laboratories, clinics, etc., and would permit a number of alternative plans or "modes" for setting up medical service, in fact the employment of physicians on salaries if deemed necessary.

While the primary provision in the measure would permit beneficiaries of the act to select their own physicians who are on a list or panel, and any duly qualified physician would be permitted to register on such basis, general authority would be granted to the administrative officials of the fund to establish almost any or all kinds of set-ups for medical and hospital care in case they did not approve of the primary set-up.

The proposal does not establish a definite fee schedule but the provisions of the bill are so general that practically unlimited authority would be invested in the administrators of the fund and they could regulate fees if they saw fit to do so.

Socialization Advocates Use Radio for Their Propaganda

Many members of the medical profession undoubtedly are aware of the series of radio programs being broadcast every Monday evening over the Columbia network under the title "Doctors, Dollars and Disease".

These programs are said to be presented under the auspices of the Public Health Committee of the National Advisory Council on Radio in Education, Inc., an organization claiming to be "independent of faction, nonpartisan in its procedure, disinterested as to personnel and noncommercial in operation" and especially interested in the purpose of "furthering the development of the art of radio broadcasting in American Education".

Coming at a time when the proponents of the socialization of medicine in America are staging their most vigorous drive for the enactment of legislation in Congress and the different states (including Ohio) to bring this about, these programs are of unusual significance.

Many physicians who have heard the programs so far presented and are acquainted with those sponsoring them and the speakers engaged to take part in them are convinced that this is no less than an attempt on the part of the interests represented in the majority report of the Committee on the Costs of Medical Care and others holding similar beliefs to further the propaganda for socialized and governmental medicine.

The Public Health Committee which arranged the series of addresses is headed by William Trufant Foster, Boston economist, a signer of the majority report of the Committee on the Costs of Medical Care and whose bitter attacks on organized medicine are known to many members of the profession.

Associated with Mr. Foster on the committee are: Dr. Ray Lyman Wilbur, chairman of the Committee on the Costs of Medical Care and signer of its majority report; Dr. Thomas Parran, Jr., state health officer of New York, who is committed to compulsory health insurance; Dr. Haven Emerson, signer of the majority report on the costs of medical care; Dr. Alice Hamilton, noted authority on and investigator of industrial diseases but whose writings indicate leanings toward the social control of medicine, and Dr. Hugh S. Cumming, surgeon general of the U. S. Public Health Service.

Among those scheduled to discuss the questions of medical care and medical economics in these nation-wide broadcasts are: Dr. Walter P. Bowers, editor of the *New England Journal of Medicine*, Dr. George H. Bigelow, Edward A. Filene, Michael M. Davis, C. Rufus Rorem, Nathan Sinai, I. S. Falk, Edgar Sydenstricker, and Harry H. Moore, all of whom have played prominent roles in the program for radical changes in the nature of medical practice and advocates of the majority report of the Committee on the Costs of Medical Care. Additional speakers include: Dr. Parran, Dr. Emerson, Dr. Wilbur, Mr. Foster, Paul H. Douglas, University of Chicago, Robert Jolly, Houston, Texas, and Dr. Livingston Farrand, president of Cornell University, the system of pay clinics of which have been the subject of much medical discussion.

The committee or speakers' list contains no present official representative of organized medicine and both are overwhelmingly controlled by the state medicine and socialization of medicine point of view.

Comments of Head of College of Surgeons Given Wide Publicity

Considerable space in the daily press was given to the presidential address of Dr. Robert B. Greenough, Boston, at the recent clinical congress of the American College of Surgeons, at Boston,

under headlines stating or implying that Dr. Greenough as spokesman had committed the surgeons of the country to some radical system of governmental-administered or socialized medicine.

Some physicians who heard Dr. Greenough's address or have had the opportunity to study abstracts of it are of the opinion that the news reports pertaining to it were exaggerated and that neither he nor the American College of Surgeons has advocated a program unusually radical.

The following official abstracts of Dr. Greenough's remarks on medical economics is presented to give physicians who read newspaper accounts accurate information on what he actually said:

"It is an accepted principle that the medical and surgical care of the indigent sick is a community obligation. Only recently, and we hope temporarily, has it been necessary to call upon the state or the federal government for financial support of these community responsibilities.

"From the point of view of their ability to pay for medical and surgical service there are at least three classes of the community to be considered.

"1. The indigent, who cannot pay at all.

"2. Those of adequate means who can afford to pay for what they need.

"3. The intermediate group of those of moderate means who can pay for minor medical service, but cannot finance unaided the expenses of serious illness or prolonged hospitalization within their restricted incomes.

"The care of the indigent sick is recognized as an obligation on the community, but too often this community burden is placed on the shoulders of the physician alone and he is expected and permitted to care for the indigent sick without compensation.

"The physician who serves the community should not be expected to stand in any different relation from that of other professional men such as lawyers or engineers who qualify for the public service.

"This fact has recently been recognized by the federal government in providing and paying for the medical care in their homes or in the doctor's office, of the dependents in the FERA and the CWA. This principle should be maintained.

"The medical and surgical care of the well-to-do, is reasonably well organized at the present time. It is the great moderate-means class of the population, however, that fails most frequently to obtain efficient service. When serious illness comes to the moderate-means patient staggering obligations in the way of debts must be assumed or the individual must lose his independence and become a burden on the community. It is to this group of the population that it has been proposed that the prepayment insurance principle be applied.

"Voluntary or compulsory measures for health insurance have been instituted in many countries in the past 30 years. Some of these plans, as in Russia, involve the complete socialization and regimentation of medicine; a condition which is abhorrent to our Western civilization, and a form of practice which as "State medicine" is regarded as a menace to the best interests of the medical profession and to the community as well. Other plans, such as the British Health Insurance Act involve less revolutionary changes and to this extent are looked upon with less disfavor.

"For a country so large and so diversified in population and in resources as the United States it is not to be expected that any single national health insurance project should prove everywhere satisfactory. The problem is at present essentially a local one to be studied and solved by the members of the individual communities and by trial and error, if by no other means. In these experiments the medical profession must take the lead.

"The prepayment insurance principle appears to be in fact about the only way in which those of the moderate means group can be expected to pay either the hospital or the physician for the medical and surgical services they need. Such projects as have been started experimentally have been restricted to relatively small and homogeneous groups of the population. State wide plans of this nature have not yet been put in operation. To escape the dangers of commercialism and unfair competition, plans of this sort should include all of the medical and surgical agencies of the community which are qualified and willing to give this service. The college has further recommended that these plans should be 'free from the intervention of commercial organizations operating for profit,' in order that the maximum amount of the fund may be available for the payment of the medical, surgical and hospital service which is supplied.

"The moderate-means group includes all those with incomes above the indigent class and below the "well-to-do". It would not be unreasonable, however, to make a further subdivision of this large class into two smaller groups—(1) those on the *lower-level*, whose resources unaided, even on a prepayment basis could not be expected to meet the entire cost of medical, surgical and hospital care, and (2) those of the *upper-level*, who can, through periodic payments assure themselves of sufficient resources to obtain the services they need.

"The difference between the amounts which the lower-level group can pay and the actual cost of the service must be obtained from other sources. In this case, as in the case of the indigent, this responsibility must devolve first upon the community.

"The upper-level group of the moderate means class can carry their own medical and surgical ex-

penses, provided hospital accommodation and efficient medical and surgical service can be supplied to them on a minimum cost basis. Intermediate wards to provide such service have been widely developed in the last few years. Voluntary prepayment plans for hospital, or even for full medical and surgical service can undoubtedly be developed in connection with such middle rate services; but they should not be restricted to individuals or small groups. They should rather be organized as a cooperative community effort to avoid all suggestion of unfair competition.

"No single health insurance plan of national scope appears at present to be applicable to the conditions existing in this country. The matter is at present one for local study and experiment; in which the best medical and surgical ability in the community is needed, acting in cooperation with others qualified by their knowledge of economic conditions to join in the study of the problem."

Study Outline No. 6

SYMPOSIUM ON HEART DISEASE

THE sixth of the series of "Study Outlines" being presented in *The Journal* consists of an arrangement of outlines on three different phases of heart disease.

The outline on "Coronary Thrombosis and Angina Pectoris" was prepared by Dr. Richard Dexter, Cleveland, and the outline on "Rheumatic Heart Disease" by Dr. William H. Bunn, Youngstown. Dr. Roy W. Scott, Cleveland, formulated the third outline of the symposium which deals with "Syphilitic Heart Disease".

It is believed by utilizing these three outlines together, the program committees of county medical societies could arrange a profitable and interesting program on one of the important current medical subjects.

However, each study outline has been formulated in such a way that it can be used separately if desired, making it possible to devote three consecutive meetings to the general subject of heart disease.

The outlines are as follows:

Coronary Thrombosis and Angina Pectoris

By RICHARD DEXTER, M.D.
CLEVELAND, OHIO

OUTLINE FOR STUDY

Coronary Thrombosis

1. The coronary arterial system:
   - A. Course and area supplied by the left coronary artery.
   - B. Course and area supplied by the right coronary artery.
   - C. The possibility of anastomosis in the area of the coronary system.
   - D. The results of occlusion of one or more of these arteries.
2. Pathology—Arterial disease in a coronary leads to:
   - A. Narrowing.
   - B. Thrombosis.
   - C. Infarction of cardiac muscle.
   - D. Scar formation.
3. Symptoms:
   - A. Sudden death.
   - B. In cases where sudden death does not occur:
     1. Onset.
     2. Cardiac pain—character—distribution.
     3. General condition—collapse.
     4. Appearance of patient.
     5. Nausea and vomiting.
     6. Restlessness—other symptoms.
4. Physical Signs:
   - A. Appearance of patient.
   - B. Breathlessness.
   - C. Heart sounds—Pericardial rub.
   - D. Condition in lungs.
     1. Moisture—extent—location.
     2. Infarction, signs of.
   - E. Pulse.
     1. Rate and volume.
     2. Rhythm.
     3. Blood pressure.
5. In cases recovering from attack—importance of delayed signs:
   - A. Fever.
   - B. Leucocytosis.
   - C. Pericardial Rub. (interpretation and significance)
   - D. Embolism—cause.
6. Diagnosis: differential—
   - A. From acute upper abdominal accident.
   - B. From "acute indigestion".
   - C. From Angina Pectoris.
   - D. Importance of electrocardiograph in diagnosis.

7. Prognosis:
   - A. Age.
   - B. Estimated extent of infarction.
   - C. Location of infarction.
   - D. Possibility of cardiac aneurysm with rupture.

8. Treatment:
   - A. Treatment of pain.
   - B. Treatment of impending cardiac failure.
   - C. Treatment in order that the infarction shall heal.
   - D. Treatment after the infarction has presumably healed.

Angina Pectoris

1. Symptoms:
   - A. Pain—location—extent—distribution.
   - B. Character of pain.
   - C. Associated symptoms.
   - D. Relation to effort—anxiety, etc.
   - E. Duration of pain.

2. Physical Condition:
   - A. Attitude in attack—appearance in attack.
   - B. Heart rate—sounds and blood pressure.
   - C. Condition after attack.

3. Diagnosis:
   - A. History of condition.
   - B. Age.
   - C. Apparent condition of arteries.
   - D. Response to effort.
   - E. Absence or presence of obvious cardiovascular lesions.

4. Prognosis:
   - A. Average life after beginning of attacks.
   - B. Variability in outlook.
   - C. Factors which make prognosis good or bad.
   - D. Eventual outcome.
   - E. Relation to coronary thrombosis.

5. Treatment:
   - A. Rest and limitation of activities.
   - B. Drugs.
   - C. Physical Therapy.
   - D. May tobacco or alcohol be used?

SUGGESTIONS FOR PAPERS

1. Clinical picture of coronary thrombosis.
2. Treatment of Coronary Thrombosis.
3. Differential Diagnosis of Coronary Thrombosis and upper abdominal lesions.
4. Diagnosis of Angina Pectoris (Angina of Effort).
5. The Rational care of a patient with Angina Pectoris.

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Dulton, Don C. and Lueth, Harold—"Diseases of the Coronary Arteries". The C. V. Mosby Company, 1932.

Rheumatic Heart Disease

By WILLIAM H. BUNN, M.D.,
YOUNGSTOWN, OHIO

OUTLINE FOR STUDY

1. INCIDENCE AND OCCURRENCE:
   - a. 1% to 1.5% in school children.
   - b. 1.5% to 2% in army recruits.
   - c. Occurs chiefly in children and young adults; infrequent after age of thirty-five; rare after age of fifty.
   - d. Much less common in warm, dry states.
   - e. Possible contagiousness.
   - f. Seasonal variation. Environment.

2. CAUSE:
   - a. Evidence points to sensitivity to hemolytic streptococcic toxins or the organism itself.
   - b. Upper respiratory infections as precursors.
   - c. Congenital lesions predispose.

3. THE RHEUMATIC MANIFESTATIONS:
   - a. Migratory polyarthritis (less common than formerly).
   - b. Chorea.
   - c. Wry neck.
   - d. Growing pains.
   - e. Tonsillitis.
   - f. Rheumatic nodules and purpura.

4. ONSET AND SYMPTOMS OF RHEUMATIC HEART DISEASE:
   - a. Classical picture not common; that is, sore throat followed by polyarthritis and concomitant or shortly ensuing signs of endocarditis or pancarditis.
   - b. Frequently no recognized throat infection nor arthritis.
     Signs and symptoms of pericarditis or endocarditis begin without other evidence of disease. Epistaxis common.
   - c. Important symptoms—fatigue, cough, palpitation, dyspnoea, precordial pain, arrythmias.

Early signs—tachycardia, fever.
Later signs—cyanosis, edema, pericardial and pleural effusions, ascites, anasarca, alterations in the electrocardiogram, development of valve murmurs.

d. Tendency for recurrence.
Rheumatic fever marked by periods of activity and periods of latency. May continue to recur for years.
Comparable in many respects to tuberculosis.
Heart may be affected in any attack.

e. Cardiac signs may not be present for months or years after attack.

f. Importance of recognizing the possibility of discovering all the signs of severe rheumatic heart damage in patients with no history of any rheumatic manifestation.
Subacute bacterial endocarditis frequently follows years after original attack. Important to recognize signs and symptoms of emboli.

g. Long, continued, unexplained fever frequently a rheumatic manifestation.

5. PATHOLOGY:
   a. Usually all structures of heart involved. Arteries of general circulation also affected.
   b. Valve lesions causing distortion.
   c. Cloudy swelling of myocardium. Aschoff bodies.
   d. Perivascular infiltration.
   e. Changes in conduction system.
   f. Pericardial synechia.

6. TREATMENT:
   a. Prophylactic—Tonsillectomy advisable; results often disappointing, especially after first attack; prolonged convalescence from upper respiratory infections in children.
   b. During active stage—Rest; salicylates; symptomatic treatment for pericarditis; pericardial paracentesis if hydrostatic pressure too high. Digitalis of little use.
   Slow return to normal activity, pulse and temperature as the guide.
   Importance of nursing care in myocardial failure.
   Value of newer diuretics.
   Treatment of chorea by hyperprexia successful.
   c. Chronic case — occupational guidance.
   Teach patient to live within reserve.
   Importance of massage and graduated exercises in convalescence from myocardial failure.
   d. Possibilities of surgery in pericardial synechia.

7. PROGNOSIS:
   a. Mortality
      (1) In acute stage.
      (2) Years later.
   b. Morbidity from
      (1) Valve damage.
      (2) Myocardial damage.
      (3) Pericardial synechia.
   c. The relentless tendency for mitral stenosis to progress and cause death at the age of thirty to forty-two years.

8. CHANGED CONCEPTIONS:
   a. Arthritis (migratory) less common.
   b. Tonsillectomy not panacea.
   c. Disease is of long duration, active then quiescent.
   d. Treatment similar to that for tuberculosis.
   e. In about 50% of adult cases no history of recognizable rheumatic manifestation.
   f. Rheumatic pleurisy may be allergic. Rheumatic lung not uncommon.
   g. The beneficial effect of climate on recurrence.

SUGGESTIONS FOR PAPERS

1. A discussion of the rheumatic manifestations, their role in long continued fevers and in subacute bacterial endocarditis.
2. Changing conceptions of rheumatic heart disease in regard to cause, prevention and treatment.

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1. Diseases of the Heart—*Sir Thomas Lewis*—Macmillan Co.
2. Heart Disease—*Paul White*—Macmillan Co.
3. Modern Concepts of Cardiovascular Disease (Rheumatic Fever)—March, 1932—*American Heart Ass'n.*, New York.
4. The Prevention and Control of Heart Disease —*W. H. Bunn*, O.S.M.J., August, 1923.
5. Nelson Loose Leaf Medicine—Chapter, Rheumatic Fever.

Note: The American Heart Association has lantern slides, charts and pamphlets which can be obtained at small cost and used to advantage in a meeting on the subject of rheumatic heart disease.)

Syphilitic Heart Disease

By ROY W. SCOTT, M.D.,
CLEVELAND, OHIO

OUTLINE FOR STUDY

Introduction: Syphilis is a significant cause of heart disease only in so far as it involves the root or first part of the aorta. The anatomical changes in this situation caused by syphilis burdens the

heart and ultimately leads to death from cardiac failure. An outline of study of syphilitic heart disease must therefore begin with a consideration of syphilitic aortitis.

1. Syphilitic Aortitis.
   - A. Incidence.
     - (1) Cite statistics to show that at post mortem the aorta is more often involved than any other organ in syphilitics.
   - B. Anatomical changes.
     - (1) Macroscopic.
     - (2) Microscopic.
2. Syphilis at the root of the aorta.
   - A. Anatomical changes in
     - (1) Aortic valve leaflets.
     - (2) Aortic ring.
     - (3) Coronary ostia.
   - B. Functional effects.
     - (1) Aortic insufficiency.
     - (2) Impaired blood supply to the heart wall.
     - (3) Congestive heart failure.
3. Syphilitic aortic insufficiency.
   - A. Incidence.
     - (1) Age—greater between 40-50.
     - (2) Race—greater in negroes.
     - (3) Sex—commoner in men.
   - B. Time interval after primary infection.
     - (1) Earliest 4-5 years.
     - (2) Latest more than 40 years.
   - C. Subjective evidence.
     - (1) Anginal syndrome.
     - (2) Paroxysmal dyspnea.
     - (3) Dyspnea.
     - (4) Palpitation.
   - B. Objective evidence.
     - (1) Peripheral vascular signs as Corrigan's pulse, capillary pulse, Durosiez's sign, etc. Usually a normal cardiac mechanism.
     - (2) Enlarged over-active left ventricle.
     - (3) Palpable systolic impulse and diastolic impact over base of heart.
     - (4) Diastolic thrill palpable over base.
     - (5) Murmurs—most often a to-and-fro blow over anatomical site of aortic orifice or 2nd right intercostal space. In some cases, only aortic diastolic murmur is audible.
       Apical diastolic murmur simulating that of mitral stenosis (Flint murmur) sometimes heard.
     - (6) *X*-ray—enlarged heart shadow particularly in region of left ventricle. Transverse position of heart with forcible pulsations—increased excursion of aorta.
     - (7) Wassermann reaction positive in about 90% of cases.
   - E. Diagnosis.
     Following facts are important.
     - (1) Free aortic regurgitation appearing insidiously in an adult with a negative cardiac history is usually due to syphilis.
     - (2) Syphilis may remain in the aorta clinically silent for a period of over 40 years. During this time the patient may have a healthy family of children and not until he is past 60 will the syphilis blossom as heart disease with aortic insufficiency.
     - (3) Simple arteriosclerosis of the aorta common in elderly people does not cause free aortic regurgitation.
     - (4) Early diagnosis important so that therapy may be instituted before serious damage is done to the heart.
   - F. Clinical course.
     - (1) Varies widely. Some patients are able to do light work for several years; in others there is more or less abrupt onset of symptoms with death from progressive heart disease in a few months.
   - G. Prognosis depends on
     - (1) Rate at which the syphilitic inflammatory process advances to destroy the aortic valves or close the coronary arteries.
     - (2) Capacity of heart to compensate for above lesions.
     - (3) Development of congestive heart failure of great significance in prognosis, since it means the beginning of the end in most cases.
   - H. Treatment—Cardinal Principles.
     - (1) Prevention by adequate treatment of primary and secondary syphilis.
     - (2) Must be extended for several years.
     - (3) Best results in patients before the stage of cardiac decompensation.
     - (4) Mercury and iodides in decompensated patients.
     - (5) Neoarsephenamine and Bismuth. Arsphenamine in compensated cases but start with small doses and increase gradually to avoid reactions.
     - (6) Patient should be treated both

from the standpoint of syphilis and heart disease, not from either alone.

SUGGESTIONS FOR PAPERS

1. Syphilitic Aortitis.
2. Syphilitic Heart Disease.

REFERENCES

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3. Conner, (L. A.) Development of Knowledge Concerning Role of Syphilis in Cardio-vascular Disease. (Frank Billings' lecture), J.A.M.A. 102: 575-581, Feb. 24, '34.
4. Stokes, (John H.) Modern Clinical Syphilology, Ed. 2, Philadelphia, Saunders, 1934.

Deaths in Ohio

George M. Bodey, M.D., North Lewisburg; Kentucky School of Medicine, Louisville, 1892; aged 69; died November 9 of heart disease. Dr. Bodey had practiced in Champaign County for the past 25 years.

William P. Clay, M.D., Convoy, Starling Medical College, Columbus, 1896; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 4 following a prolonged illness. Dr. Clay, a native of Mercer County, had practiced at Elgin and Mendon before moving to Convoy 33 years ago. His widow, one son, one daughter, one brother and one sister survive.

David M. Criswell, M.D., Coshocton; Baltimore Medical College, Baltimore, Md., 1892; aged 69; member of the Ohio State Medical Association and the American Medical Association; died October 21 of heart disease. Dr. Criswell had been health commissioner of Coshocton and Coshocton County for the past 14 years. He represented Coshocton in the State Legislature from 1913 to 1917. Dr. Criswell was a member of the Odd Fellows lodge. Surviving are his widow, two sons, two daughters and four sisters.

Edmund F. Danford, M.D., Glouster; Medical College of Ohio, Cincinnati, 1881; aged 78; member of the Ohio State Medical Association and the American Medical Association; died November 7 of heart disease. Dr. Danford retired from active practice in 1914 after practicing in Glouster for 30 years. Surviving are one son, four daughters and two brothers.

Albert B. Davenport, M.D., Columbus; Columbus Medical College, 1890; aged 73; died October 18. Dr. Davenport, who had practiced in Columbus for 41 years, was a member of the Masonic Lodge and Evangelical Church. Surviving are his widow, one son, one daughter, two brothers and one sister.

Fred F. DeVore, M.D., Toledo; Medical College of Ohio, Cincinnati, 1900; aged 55; died October 21 of heart disease. Dr. DeVore was a practicing physician at Whitehouse for 13 years prior to becoming health commissioner of Lucas County 10 years ago. During the World War he served as a lieutenant in the medical corps. He was a member of the American Legion, American Public Health Association and Knights of Pythias. His widow and one sister survive.

Henry F. Gau, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1894; aged 62; former member of the Ohio State Medical Association and the American Medical Association; died October 21. Dr. Gau had practiced in Cincinnati for 40 years. He was active in the Knights of Columbus. Surviving are his widow, four daughters and two sisters.

Nathan Hammond, M.D., Plainfield; Ohio Medical University, Columbus, 1905; aged 61; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 29 of heart disease. Dr. Hammond was chairman of the Coshocton County board of health; member of the Masonic Lodge and the Methodist Church. Three brothers and three sisters survive.

Don C. Hughes, M.D., Findlay; College of Physicians and Surgeons, Baltimore, Md., 1893; aged 63; member of the Ohio State Medical Association and the American Medical Association; died September 25 of apoplexy. He was a native of Findlay and had practiced there 40 years. Dr. Hughes was a member of the Sons of Union Veterans and Moose and Elks lodges. He was medical director of the Modern Woodmen of America.

William G. Jacobs, M.D., Cincinnati; Miami Medical College, Cincinnati, 1903; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died September 26 following a cerebral hemorrhage. He was a life-long resident of Cincinnati. His widow, two brothers, one whom is Dr. P. X. Jacobs, Cincinnati, and one sister survive.

Reuben W. Mondhank, M.D., Lancaster; Ohio Medical University, Columbus, 1896; aged 60; member of the Ohio State Medical Association and the American Medical Association; died November 12 of Hodgkins' Disease. Dr. Mondhank

had practiced in Lancaster for 30 years, being a member of the Lancaster City Hospital staff and executive board. He was a member of the Masonic, Elks and Pythian lodges and the Kiwanis Club. His widow, one son and his father survive.

James W. Overpeek, M.D., Hamilton; Pulte Medical College, Cincinnati, 1882; aged 84; died October 7. Dr. Overpeck, a native of Butler County, had practiced at Hamilton since 1888. He was a member of the Odd Fellows Lodge and the Universalist Church. His widow survives.

Jonas A. Park, M.D., Caldwell; Ohio Medical University, Columbus, 1895; aged 67; died October 5 of blood poisoning. He had practiced at Caldwell six years, and previously in Lima and Steubenville. His widow and one sister survive.

James H. Poulton, M.D., Springfield; Ohio State University, College of Medicine, 1912; aged 47; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 16 of heart disease. Dr. Poulton was a native of Barnesville and had practiced in Springfield for the past 20 years. During the World War he served in the medical corps. Surviving are his widow, two daughters, one son, one brother and two sisters.

Victor Ray, M.D., Cincinnati; Miami Medical College, Cincinnati, 1897; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 25 of heart disease. Dr. Ray graduated in engineering from the Massachusetts Institute of Technology and rose to the position of general superintendent of the Anaconda Copper Co., in Montana. In the midst of a successful career as an engineer, he elected to study medicine and upon graduation specialized in ophthalmology. At the time of his death he was emeritus professor of ophthalmology, University of Cincinnati, College of Medicine, and a member of the American Academy of Ophthalmology and Oto-laryngology and the American Board of Ophthalmology. He was a past president of the Cincinnati Academy of Medicine and former director of eye service, Cincinnati General Hospital. Surviving are his widow, two daughters, and one son, Dr. Victor Ray, Jr., Cincinnati.

Arthur F. Shepherd, M.D., Dayton; Medical College of Ohio, Cincinnati, 1893; aged 69; member of the Ohio State Medical Association and the American Medical Association; died October 29 of heart disease. Dr. Shepherd was superintendent of the Dayton State Hospital from 1902 to 1911 and a former member of the old State Board of Administration and the old prison commission. He was the organizer of the Bureau of Juvenile Research. He was a native of Hillsboro.

Samuel M. Sproat, M.D., Chillicothe; University of Michigan, Medical School, 1913; aged 45; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 9 of injuries sustained in an automobile accident. Dr. Sproat was a native of Ross County. He had served as a surgeon for the Union Pacific Railroad on the West Coast and later practiced at Pontiac, Michigan, before he opened offices in Chillicothe. He belonged to the American College of Surgeons. Surviving are his widow, one son, one daughter, a brother and two sisters.

William G. Stevens, M.D., Catawba; Eclectic Medical College, Cincinnati, 1889; aged 71; died October 21. His widow, one daughter and one sister survive.

James Wiltshire, M.D., Londonderry; Starling Medical College, Columbus, 1897; aged 74; member of the Ohio State Medical Association and the American Medical Association; died October 30. He was a native of Mooresville and had practiced at Londonderry for many years. Surviving are his widow, one son, one sister and one brother.

Clarence B. Wean, M.D., Cherry Valley; Western Reserve University, School of Medicine, 1901; aged 57; former member of the Ohio State Medical Association and the American Medical Association; died October 14 of angina pectoris. He had retired from active practice five years ago. One daughter and one sister survive.

KNOWN IN OHIO

Elwood E. Arnold, M.D., Hollywood, California; Starling Medical College, Columbus, 1895; aged 67; died October 4 following a nervous breakdown. Dr. Arnold had been for many years a practicing physician at New Salem, Ohio. He is survived by his widow, his father and one brother.

Carey A. Burke, M.D., Los Angeles, California; Ohio Medical University, Columbus, 1895; aged 65; died October 7 following a stroke of paralysis. Dr. Burke had practiced at Johnstown for 20 years before moving to California.

Russell Miller, M.D., Gleason, Wisconsin; Columbus Medical College, 1880; aged 77; died September 19. He at one time practiced in Amanda, Ohio.

— OSMJ —

Blanks For Scientific Exhibit Space at A. M. A. Meeting Available

Application blanks are now available for space in the Scientific Exhibit at the Atlantic City Session of the American Medical Association, June 10-14, 1935. The Committee on Scientific Exhibit requires that all applications be filled out on the regular form and requests that this be done as early as convenient. Applications close February 25, 1935.

Persons desiring application blanks should address a request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

PROTECTION OF WATER SUPPLIES AND PROPER SEWAGE DISPOSAL MAJOR PUBLIC HEALTH PROBLEMS, DIRECTOR OF HEALTH SAYS

Fifteenth Annual Conference of Ohio Health Commissioners with the State Department of Health was held and well-attended at the Deshler-Wallick Hotel, Columbus, November 14, 15 and 16.

The program covered many important phases of public health administration, including: Studies of the prevention and control of amoebic dysentery; management of tuberculosis in children; value of vital statistics; addresses on encephalitis, typhoid fever and malaria; child hygiene activities; post-graduate work in public health; public health work in institutions; water and milk sanitation; problems of public health nursing, and discussions of administrative and legislative questions bearing on public health.

Because of the conflict between the time of the conference and the press time of *The Journal*, it was impossible to publish a detailed account of the meeting in this issue. However, a more complete article on the conference will be carried in the January issue of *The Journal*.

Inasmuch as the conference was officially opened by the annual address of the State Director of Health, Dr. H. G. Southard, a synopsis of Dr. Southard's interesting and informative address on "Streams of Ohio" was available for this issue.

Dr. Southard pointed out by way of introduction that the settlement and development of Ohio has been intimately associated with its inland waterways and that in modern time the public health of the state is vitally concerned with the sanitary conservation of surface waters, an activity which is receiving an increasing amount of attention from the official public health forces of the state.

Following a short historical sketch of the influence of streams on early colonial settlements and upon the economic and social life of the pioneers who settled Ohio and the other territories, Dr. Southard told how waterways and water supply played a major role in the development of Ohio's great centers of population and discussed some of the water problems which have arisen because such a large percentage (68 per cent) of Ohio's population now resides in communities having more than 2,500 people.

SURFACE WATER A HEALTH MENACE

"With the change from rural to community life on a large scale there have arisen all sorts of public health problems," he said.

"Among the most important of these are domestic water supply, domestic sewage and industrial water disposal and industrial water supply.

"The concentration of people in cities and the use of the water carriage method of sewage and wastes disposal have complicated our living conditions and menaced the public health through pollution of the very streams and natural waters that were the cause of the cities' locations and developments.

"No longer is it safe to drink the surface waters of the area without first resorting to highly scientific means for purifying such water; and no longer can we go on discharging indiscriminately into these natural waters the waste products of our domestic and industrial civilizations.

"The old saying that "There is a limit to all things" now applies with striking force to the discharge of untreated sewage and wastes into our streams and lakes. Furthermore, the requirment of large volumes of water to supply both domestic and industrial demands for our rapidly growing urban population has placed an added burden upon the already great problem of public water supply.

"Unfortunately, the geology of Ohio is not favorable for the development in great volume of an adequate and potable water supply from Nature's own filtration plant, i.e., the percolation and travel of surface water by rainfall and otherwise into and through the ground formations. Our surface water streams and lakes, therefore, remain to a large extent necessary for us to preserve and conserve if our people are to prosper and enjoy the advantages rightfully belonging to them.

"Some idea of the dependence which, as a people, we in Ohio are placing upon our surface waters may be gained from a brief scrutiny of the following facts:

"By far the most important use of these surface waters is for domestic public water supply for our urban population. The number of persons served from public water supply systems is etsimated to be about 4,800,000, or about 72 per cent of the state's total population; and of this number of persons 3,500,000, or about 54 per cent of the state's total population, depend upon public water supplies obtained from surface sources.

"Expressed in another way, nearly three-fourths of our urban population are thus served by public water supply systems using our surface waters; and this large proportion of our urban population resides in about 160 municipalities. All but three small communities of this number are protected by modern water treatment works.

"Because of the fact that many communities purchase water from adjacent larger municipali-

ties, the number of these surface water purification works is about 75.

"Lake Erie and Ohio River are the two most important sources. Lake Erie supplies 1,358,000 persons; Ohio River supplies 659,000; and our various inland streams 1,483,000.

"These inland streams comprising sources of public water supplies, are listed in the following table:

Public Water Supplies Derived from Surface Sources in Ohio

Source	Population Served
Lake Erie	1,358,000
Ohio River	659,000
Maumee River and Tributaries	353,420
Scioto River and Tributaries	325,066
Mahoning River and Tributaries	281,264
Cuyahoga River and Tributaries	264,561
Muskingum River and Tributaries	96,939
Sandusky River and Tributaries	44,549
Great Miami River and Tributaries	26,592
Miscellaneous small streams	90,609
Total supplied from surface sources	3,500,000"

Dr. Southard discussed some of the problems relative to the disposal of sewage and industrial wastes, pointing out that congestion of population and concentration of manufacturing have made this one of the most difficult questions confronting public health authorities.

"It takes no great imagination," he said, "to portray the evils possible from the use of a stream for public water supply purposes into which has been emptied upstream the sewage and industrial wastes of a great municipality.

"Although nature can accomplish wonderful things in the course of time, the old adage of 'Running water purifies itself' is extremely deceiving. Rarely does there exist time and other natural agencies sufficient to dissipate completely the bad effects of sewage and other liquid wastes from a modern city.

"Therefore it has become imperative for our municipalities to purify all water taken from the streams for public water supply purposes; and also to treat to some degree sewage and liquid wastes returned to the stream, the degree of treatment depending principally upon the dilution afforded by the stream and the uses to which the stream is put below that municipality within reasonable distances.

"Obviously the same incentive is not apparent within a municipality for proper sewage treatment as exists for proper purification of drinking water.

"If all our cities were in the position of Portsmouth on the Ohio River, or Cleveland and a few other Lake Erie cities where their own liquid wastes affected their own water supplies, we would have an easy time bringing about suitable corrections.

"Unfortunately for the rate of progress in sewage treatment cities do not desire to spend money to treat their wastes for the protection of a downstream neighboring city or riparian owner. Much popular education must be given; in many instances lawsuits for damage have assisted; and again persuasion, legal or otherwise, has been necessary in numerous instances before the needed improvements are installed and operated properly.

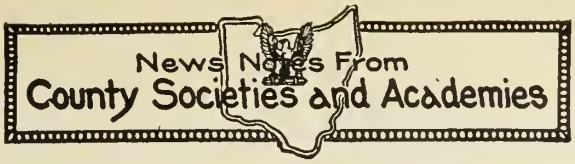
"There are 89 municipal sewage treatment plants in the state. These plants serve a population of approximately 2,650,000 persons. While all of these plants provide some degree of purification of the sewage from the municipalities, not all of them provide a sufficient degree of purification to eliminate entirely the objectionable stream conditions downstream from the municipalities which they serve, especially during periods of low stream flow.

"It is estimated that 60 of the 89 sewage treatment plants, or a little more than two-thirds of them, may be classed as satisfactory in protecting against stream pollution by municipal sewage. While this situation may not appear to be as favorable as one might have hoped for, nevertheless by contrast with conditions existing eight or ten years ago, a remarkable improvement has been made.

"Municipal water supply, water purification, sewage disposal, industrial waste disposal, all go hand in hand to make out an exceedingly complex and difficult problem in which sanitation and the public health and comfort appear of prime importance."

The statutory authority given the State Department of Health to control water supplies, sewage disposal, industrial wastes, etc., was reviewed by Dr. Southard. He pointed out that legislation restricting expenditures by municipalities for public works improvements, including water purification and sewage treatment works, to vote of the people for approval had made it more difficult for the Department to carry on its campaign of having communities provide themselves with these vital public services. Dr. Southard urged that more cities make use of the sewer rental plan to raise funds for proper operation of sewage treatment plants. He lauded Ohio industry generally for its cooperation on the question of industrial wastes, pointing out millions of dollars have been expended by industry to prevent or correct pollution of public water supplies.

Dr. Southard reviewed the activities of the Sanitary Engineering Division of the State Department of Health in connection with sanitation projects carried on as emergency relief measures and said that as a result of this campaign many badly needed water supply and sewage purification prospects are now under way throughout the state, at a total cost of approximately $45,000,000. In addition, he cited the numerous stream cleaning, water conservation and mine sealing projects, and similar activities, now being carried on for the protection of the health of the people in all parts of the state.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

Annual meeting of the *First Councilor District* was held November 12 at the Cincinnati General Hospital, with Dr. Parke G. Smith, councilor of the District, presiding.

Following an inspection of the Cancer Clinic of the Cincinnati General Hospital, the visiting physicians assembled in the surgical amphitheatre where five unusual cases of malignancy were reported and discussions presented by Dr. Frank E. Adair, New York surgeon, and Dr. James Ewing, professor of oncology, Cornell University, College of Medicine, the guest speakers.

A round-table discussion on problems of malignancy was conducted by Dr. Adair and Dr. Ewing at a luncheon at the Vernon Manor Apartments before the afternoon program which included the following addresses:

"A Simple Measure of Thyroid Disfunction", Dr. Robert Conard, Wilmington; discussant, Dr Henry Brown, King's Mills.

"Some Phases of Peripheral Vascular Disease", Dr. Louis G. Herrmann, Cincinnati.

"Pyelitis in Infancy and Childhood", Dr. Harold O. Lund, Middletown; discussant, Dr. Harold F. Downing, Cincinnati.

"Treatment of Thermal Burns", Dr. H. M. Lowell, Hamilton; discussant, Dr. Mark Millikin Hamilton.

A joint meeting with the Cincinnati Academy of Medicine was held in the evening at the Academy headquarters which was addressed by Dr. Adair on "The Attitude of the Modern Surgeon Toward the Cancer Problem," and Dr. Ewing on "Recent Advances in the Scope of Cancer".

* * *

The following programs were presented at regular meetings of the *Cincinnati Academy* during November:

November 5—"Sudden Death", Dr. Julien E. Benjamin; discussants, Dr. Louis G. Herrmann and Dr. Scott Kearns; "Skin Disorders in Systemic Disease", Dr. Daniel J. Kindel; discussants, Dr. Elmore B. Tauber and Dr. David A. Tucker, Jr.

November 19—Theoretical and Practical Aspects of Gas Therapy: "Physiological Considerations", Dr. Dennis E. Jackson; "Clinical Indications", Dr. Moses Salzer; "Technical Problems", Dr. A. L. Schwartz.

November 26—"Bronchiectasis", Dr. John H. Skavlem; discussants, Dr. Jacob Teuchter and Dr. Nolan Carter; "Coronary Thrombosis", Dr. E. I. Fogel; discussants, Dr. J. E. Benjamin and Dr. B. A. Schwartz.

Adams County Medical Society at its regular meeting October 17 at Hotel Hester, elected the following officers for the ensuing year: President, Dr. Robert B. Ellison, Peebles; vice president, Dr. M. L. Purdin, West Union; secretary-treasurer, Dr. O. T. Sproull, West Union; delegate, Dr. Ray Vaughen, Cedar Mills; legislative committeeman, Dr. S. J. Ellison, West Union. The guest speaker was Dr. Wells Teachnor, Sr., Columbus, who spoke on "Cancer of the Rectum and Colon".—News Clipping.

Clermont County Medical Society in session November 21 at Owensville was addressed by Dr. William Muhlberg, Cincinnati, and Dr. Louis Feid, Jr., Cincinnati.—News Clipping.

Warren County Medical Society was addressed on November 6 at Lebanon by Dr. Thomas C. Sheridan of Dayton, who spoke on "Eczema".—News Clipping.

Second District

Greene County Medical Society met October 12 at the Court House, Xenia. The guest speaker was Dr. A. L. Van Horn, chief of the Bureau of Child Hygiene, State Department of Health. He discussed "Infant Mortality".—News Clipping.

Miami County Medical Society met in regular session November 2 at Stouder Memorial Hospital, Troy. The guest speaker was Dr. J. C. Walker, Dayton. The subject of his paper was "The Treatment of Fractures of the Forearm".—Bulletin.

Montgomery County Medical Society had as its guest speaker November 2, Dr. Sumner L. Koch, Chicago, who spoke on "Acute Infections of the Hand".

On November 16 the society was entertained for dinner by the Miami Valley Hospital, following which Dr. C. C. Sturgis, Ann Arbor, Michigan, spoke on "Newer Developments in the Management of the Anemias".—Bulletin.

Preble County Medical Society met November 15 at Seven Mile Tavern, Eaton. Dr. M. O. Cook, Hamilton, addressed the society on "Arterio-Venous Aneurysm".—Bulletin.

Third District

Hancock County Medical Society was addresed on November 1 at the Elk's Club, Findlay, by Dr. E. A. Ockuly, Chicago. Dr. Ockuly presented a lantern slide talk on "Changes in the Ureters

and Kidneys During Pregnancy". The speaker's father, Dr. J. F. Ockuly, Delphos, was a guest of the society.—H. O. Crosby, M.D., Secretary.

Hardin County Medical Society met October 18 at Kenton. Dr. J. P. Harbert, Bellefontaine, was the guest speaker, discussing "The Mendelian Law".—News Clipping.

Logan County Medical Society at its meeting October 5 was addressed by Dr. A. Graeme Mitchell, Cincinnati.

On November 6 the society was addressed by Dr. George T. Harding, III., on "Various Neurological Conditions". At the business session, the following officers for the ensuing year were elected: President, Dr. C. K. Startzman, Bellefontaine; vice president, Dr. H. L. Mikesell, West Liberty; secretary-treasurer, Dr. M. L. Pratt, Bellefontaine; delegate, Dr. Startzman; legislative committeeman, Dr. John P. Harbert.—News Clipping.

Marion County—The regular meeting of the Marion Academy of Medicine was held October 9 at the Marion City Hospital. Dr. David Steel, Cleveland, was the guest speaker, presenting a very interesting lecture on "The Common Non-Tuberculosis Lesions of the Chest as Seen with the *X*-ray". Dr. J. W. Jolley gave a historical sketch on *X*-ray and Dr. John Dodd submitted a case report.

On November 6 the Academy was addressed by Dr. J. J. Sutter, health commissioner of Allen County and Mrs. Elizabeth T. August, general secretary, Ohio State Nurses' Association. Dr. Sutter spoke on "The Value of Public Health to the Community". Mrs. August discussed nursing problems.—J. W. Jolley, M.D., secretary.

Fourth District

Sandusky County Medical Society met October 25 at Fremont. The following program was presented: "Encephalitis", Dr. E. A. Baker, Clyde; "The Use of Thorium in *X*-ray Diagnosis of Diseases of the Liver", Dr. H. K. Shumaker, Bellevue; and "Hyperthyroidism", Dr. J. L. Curtin.—News Clipping.

Wood County Medical Society met October 18 at the Woman's Club, Bowling Green. Dr. J. W. Rae, Toledo, was the guest speaker. He discussed "The Role of Physical Therapy in the Treatment of Arthritis".—News Clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

November 2—Clinical and Pathological Section. Program: "Dermatological Cases", Dr. R. E. Barney; "Aortic Aneurysm", Dr. Herman Shube; "The Use of Insulin in Athrepsia", Dr. J. A. Garvin; "Bilateral Cryptorchidism with Torsion of Both Testes", Dr. R. S. McGinnis; "Fundamental Principles Involved in Surgery of the Prostate", Dr. C. A. Bowers; "The Use of Sodium Dinitrophenol", Dr. M. I. Sparks.

November 9—Joint meeting of Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program: "Studies in Growth", Dr. N. C. Wetzel; "A Comparative Study of the Antirachitic Potency of Irradiated Milk and of Yeast Milk", W. E. Krauss, Ph.D., R. M. Bethke, Ph.D., and Dr. H. J. Gerstenberger; "Studies on the Role of Absorption in the Pathogenesis of Rickets", Dr. W. Heymann; "Further Studies in Whooping Cough", Dr. J. A. Toomey.

November 14—Practice of Medicine Section. Program: "The Newfeld Rapid Sputum Typing Method in Lobar Pneumonia", Dr. Charles S. Hudson and Dr. G. S. Shibley; "The Serum Treatment of Lobar Pneumonia with Comments Upon the Prognostic Value of the Icteric Index", Dr. G. S. Shipley; "Pneumothorax in the Treatment of Lobar Pneumonia", Dr. S. E. Wolpaw.

November 16—General Session. Address: "The Present Status of Chest Surgery", Dr. John Alexander, University of Michigan.

November 20—Military Medicine Section. Program: "Experiences of a Consulting Surgeon with the A.E.F.", Dr. George W. Crile.

November 21—Industrial Medicine and Orthopedic Section. Program: "Physical Examinations of Workers in the Chemical Industry", Dr. Bradford C. Scudder; "Observations on the Toxicity of Certain Metals", Dr. A. G. Cranch; "Infections of Hands Associated with the Meat Packing Industry", Dr. George Gilpin; "Bursitis and Tenosynovitis in Industry", Dr. G. F. Sykes; "Heat Effects", Dr. R. C. Engle.

Ashtabula County Medical Society met November 13 at Hotel Ashtabula, Ashtabula. A report on "The Socialization of Medicine" was presented by Dr. R. B. Wynkoop and the society voted to go on record as protesting the enactment of legislation providing for the governmental administration of medical practice. A paper on "Mistakes I Have Made in Pediatrics", was read by Dr. A. W. Thomas and one on "Carcinoma of the Lung", by Dr. P. J. Collander. Dr. H. L. Hiles, Conneaut, was elected to membership.

On October 16, the society was addressed by Dr. L. J. Karnosh, Cleveland, on "Recent Advances in the Psychology of the Pituitary Region".—A. M. Mills, M.D., Secretary.

Lake County Medical Society at its meeting October 30 at Lake County Memorial Hospital heard reports on the recent Annual Meeting of the State Association and an address by Dr. M. A. Blankenhorn, Cleveland, on "The Anemias of Intoxication and Infection".—News Clipping.

Sixth District

The 229th session of the *Union Medical Association* of the Sixth Councilor District was held at Hotel Wooster, Wooster, November 7. The following program, arranged by Dr. Joel B. Holston, Massillon, president; Dr. J. H. Seiler, Akron, secretary, and Dr. H. S. Davidson, Akron, councilor, was presented: "Treatment of Auricular Fibrillation, with Case Reports", Dr. D. D. Shontz, Massillon; "The Recognition of Common Cardiac Irregularities", Dr. W. H. Bunn, Youngstown; "Coronary Artery Disease", Dr. R. W. Scott, Cleveland; "A Discussion of the Roentgen Diagnosis of Luetic Aortitis and the Unusual Types of Thoracic Aneurysm", Dr. David Steel, Cleveland.

Holmes County Medical Society in session October 3 at Millersburg was addressed by Dr. L. E. Leavenworth, Canton.—News Clipping.

Mahoning County Medical Society and the Corydon Palmer Dental Society held their annual joint meeting on November 27 at the Youngstown Club. The guest speaker was Weston A. Price, D.D.S., Cleveland, who spoke on "New Light on How Modern Civilization Destroys Teeth and Health". —Bulletin.

Portage County Medical Society in session October 11 at the office of Dr. S. A. Brown, Kent, was addressed by Dr. W. H. Bunn, Youngstown, on "Review of Cardiac Irregularities".

On November 1, the society was addressed by Dr. Theodore Miller, Cleveland, at its meeting at the home of Dr. George J. Waggoner, Ravenna. Dr. Miller discussed "Obstetrics".—Bulletin.

Summit County Medical Socicty in session November 6 at the Mayflower Hotel, Akron, was addressed by Dr. F. C. Herrick, Cleveland, on "Purulent Appendicitis with Rupture of the Appendix".—Bulletin.

Wayne County Socicty met October 9 at Wooster. Dr. Walter G. Stern, Cleveland, was the guest speaker. He discussed "Compound Fractures" and then made pertinent comments regarding problems of medical economics.—News Clipping.

Seventh District

Belmont County Medical Society, the Belmont County Dental Society and the Belmont County Pharmaceutical Society held their second annual joint meeting November 2 at Ferryland Villa, Martin's Ferry. Scientific papers were presented by Dr. D. A. McGregor, Wheeling, and Dr. O. F. Covert, Moundsville, West Virginia. Round-table discussions on socialized medicine and the present method of providing medical care for the indigent were held.—Bulletin.

Columbiana County Medical Society met October 16 at the American Legion Club, Lisbon. Following dinner, Dr. Walter G. Stern, Cleveland, addressed the society on "Treatment of Fractures". —News Clipping.

Tuscarawas County Medical Society had as its guest speaker on November 8 Dr. Carll S. Mundy, Toledo, who spoke on "Arthritis".—Bulletin.

Eighth District

Approximately 100 physicians attended the annual Fall meeting of the *Eighth District Medical Society* held at the Elks' Hall, New Lexington, November 1. The program was arranged by Dr. F. J. Crosbie, Dr. J. H. Clouse and Dr. C. B. McDougal.

After an enjoyable dinner, Dr. D. G. Ralston, McConnelsville, president of the society, called the meeting to order. A vocal program was presented by Mrs. A. M. Kishler and Mrs. C. B. McDougal, accompanied by Miss Flossie Daniels.

The guest speakers were: Dr. C. W. McGavran, Columbus, who spoke on "Some Problems Relating to the Colon"; Dr. Julien Benjamin, Cincinnati, whose paper was on "Some Present Day Conceptions in the Prevention of Heart Disease"; and Dr. Frank W. Harrah, Columbus, who discussed "Urology From the Standpoint of the General Practitioner".

The society accepted the invitation of Rocky Glen Sanatorium, McConnelsville, to hold its Spring meeting there.—C. E. Northrup, M.D., Secretary.

Athens County Medical Society in session October 1 at Nelsonville had as guest speakers, Dr. Leo Bean and Dr. N. A. Martin, both of Gallipolis. Dr. Bean read a paper on "Bronchiectasis", and Dr. Martin discussed "Commoner Diseases of the Nose and Throat".—News Clipping.

Guernsey County Medical Society met November 15 at Cambridge and was addressed by Dr. Wayne Brehm, Columbus, on "Judgment and Mortality in Obstetrics and Gynecology".

On November 1, the society heard a paper by Dr. A. G. Ringer, Cambridge, on "Mistakes in *X*-ray Technic". —News Clipping.

Muskingum County—November meeting of the Muskingum County Academy of Medicine was held on November 7 at the University Club, Zanesville. George C. Cadwallader, D.D.S., read a paper on "Vincent's Angina", and Dr. A. E. Walters spoke on "War Experiences from a Medical Standpoint".—Bulletin.

Washington County Medical Society in session November 14 at Marietta Memorial Hospital held a symposium on "Colles' Fracture".—Bulletin.

Ninth District

Scioto County—The Hempstead Academy of Medicine met in regular session November 12. The DeLee sound film on "Obstetrics" was shown.

A buffet supper was served following the meeting.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(J. H. Mitchell, M.D., Secretary)

November 5 — General session. Program: "Treatment of Acute Appendicitis—A Study of 3,000 Cases", Dr. Mont R. Reid, Cincinnati; discussion opened by Dr. J. F. Baldwin.

November 12—General Session. Program: "Blood Diseases in Which Splenomegaly Occurs" —differential diagnosis, Dr. B. K. Wiseman; therapeutic rationale, Dr. Charles A. Doan; surgery of spleen, Dr. George W. Curtis; discussion opened by Dr. Andre Crotti and Dr. Verne Dodd.

November 19—General Session. Program: "Back Injuries", Dr. E. Harlan Wilson; discussion opened by Dr. Cassius Shepard.

November 26—General Session. Program: "Advantages of Electro Surgical Obliteration of the Gall Bladder Over Classical Cholecystectomy" (with motion pictures), Dr. Max Thorek, Chicago.

Knox County Medical Society met on October 25 at the Alcove, Mt. Vernon. The guest speaker was Dr. Earl H. Baxter, Columbus.—News Clipping.

Morrow County Medical Society in session October 2 was addressed by Dr. C. G. Smith, Marion.

— OSMJ —

Fifty-Fifty Break Won By Charter Group at Polls

Eight counties in Ohio voted at the recent general election on the question of establishing charter commissions to formulate a program of reorganization of the form of county government within those counties, under the Home Rule Amendment to the Constitution. November, 1934, issue *The Journal*, pages 769-772).

Four counties, Cuyahoga, Hamilton, Lucas and Mahoning, returned a favorable vote on the question, authorizing the formation of charter commissions which will submit reorganization plans to be voted on in November, 1935.

The other counties voting on the question, Franklin, Montgomery, Summit and Stark, defeated the proposal.

Charles P. Taft, 2nd, Cincinnati, leader of the county reorganization movement, has announced legislative proposals would be submitted to the State Legislature at its regular session this Winter, setting up alternative plans of county government reorganization. These plans, if approved by the Legislature, could be placed before the voters of any county in the Fall of 1935 through initiated petition or by vote of the county commissioners.

It is understood the Legislature will be asked to approve plans of county government calling for a county manager, a county commission or a single executive with an advisory council.

Movement to Reduce Mortality of Mothers and Babies Lauded

Ohio always has been fortunate in having leaders in medical progress. This was further exemplified in the recent formation of the Hospital Obstetric Society of Ohio. For years it has been known that the maternal death rate in the United States has been excessively high in comparison with other countries. Much has been said—but little has been done. The banding together of the state's most able obstetricians, "to develop better methods for the hospitalization and care of the obstetrical patient and the newborn child", marks a forward step in dealing with this important problem.

Approximately 600 mothers die every year in Ohio as a result of childbirth. It is estimated that at least 60 per cent of this loss could be averted if the public could be informed on proper prenatal care and on the necessity of able medical attention during the prenatal, natal and post-natal periods. In a recently conducted survey of maternal deaths in the United States, it was found that 15 per cent of the fatalities occurred in women whose pregnancy terminated before the third month, either spontaneously or intentionally. In the remaining group of those who might have received prenatal care, 54 per cent had not consulted a physician before confinement. In only 1 per cent of the 5,636 on whom information could be obtained was there evidence of adequate prenatal care.

Of the 105,838 births in 1932 in Ohio, only 24 per cent took place in hosiptals. This is an improvement over preceding years, but many of the cases reached hospitals only after complications had arisen demanding hospital care.

Of equal importance is the care of the newborn child. Last year 64 per cent of the infants dying in Ohio during the first year of life died in the first month. This is truly the most precarious period of a child's existence. Of the number dying in the first month 56 per cent died on the first day of life.

The Hospital Obstetric Society of Ohio has accepted the challenge of these facts and is resolved to do its part in making Ohio safe for mothers—and their babies.—*Ohio Health News.*

— OSMJ —

Crystal Compound Exploiters Nabbed

One man has been sentenced to a year in a Federal penitentiary and two others are awaiting trial on a charge of conspiring to violate the Federal Food and Drugs Act by advertising and selling "Warm Springs Crystal Compound" as coming from the springs by that name in Georgia, when as a matter of fact the "crystals" did not come from that source and were only a simple laxative, composed of Glauber's salts, similar in action to Epsom salts. The "crystals" cost only a few cents a pound and sold for a dollar a pound.



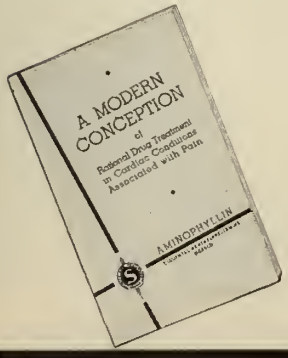
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NEWS NOTES of OHIO

Youngstown—The following local physicians gave radio talks on diphtheria prevention, sponsored by the Mahoning County Health Department and the Mahoning County Medical Society, the first two weeks in November: Drs. C. H. Beight, George Y. Davis, Charles Scofield, James B. Nelson, P. J. Fuzy, W. M. Skipp, H. E. McLenahan, H. E. Hathorn, B. W. Schaffner, J. B. Birch, C. B. Norris, J. L. Scarnecchia, L. G. Coe and R. H. Middleton.

Cincinnati—Dr. J. Edward Pirrung recently addressed the Cincinnati Knights of Columbus on "Observations During 25 Years of Medical and Economic Conditions in Europe". Dr. Pirrung recently returned from his annual visit to European clinics.

Coshocton—Dr. Samuel B. Kistler has been appointed to fill out the unexpired term of the late Dr. D. M. Criswell as health commissioner of Coshocton County.

Columbus—Dr. D. G. Sanor has been appointed secretary of Mercator International.

Hamilton—Dr. Mark Millikin, Hamilton, was elected president of the Union District Medical Association at its recent meeting here. Dr. G. W. Flory, Eaton, was elected vice president, and Dr. W. A. Thompson, Liberty, Indiana, secretary-treasurer. The membership includes physicians of southern Ohio and Indiana. Those who addressed the meeting were Dr. H. A. Moore, Oxford, retiring president; Dr. Otto J. Seibert, Cincinnati; Dr. C. O. McCormick, Indianapolis, and Dr. Harry Ross, Richmond, Indiana.

Dayton—Announcement has been made of the marriage of Miss Elta St. John and Dr. H. H. Herman.

Kenton—Dr. C. L. Johnson has been elected president of the Kenton Kiwanis Club.

Ashtabula—Dr. A. W. Thomas, who practiced here for a time 15 years ago but since then has been practicing in Youngstown, has moved here and opened offices to specialize in children's diseases.

Salem—A program was presented here recently in memory of Dr. Elizabeth Griselle, pioneer Ohio woman physician. Plans were made to raise a memorial scholarship for Western Reserve University, School of Medicine, in her honor. Those who addressed the meeting were Dr. Marion Gibbons, Cleveland, representing the Medical Women's National Association; Dr. Frederick Waite, Cleveland, professor of histology and embryology, Western Reserve University, and Dr. Julia M. Donahue, Massillon State Hospital psychiatrist.

Dr. Mouser Elected Head of Northwestern Association

Dr. H. K. Mouser, Marion, was elected president of the Northwestern Ohio Medical Association at the organization's 90th annual meeting at Toledo, recently. Other officers are: Vice president, Dr. E. E. Rakestraw; secretary, Dr. J. H. Marshall, Findlay; treasurer, Dr. E. E. Brady, Marion. The next meeting will be held in Marion.

Among those who addressed the meeting were: Dr. Raphael Isaacs, University of Michigan; Dr. Douglas Quick, Memorial Hospital, New York City; Dr. Frederick M. McPhedran, University of Pennsylvania; Dr. A. R. Morrow, St. Luke's Hospital, Chicago, and Dr. M. B. Cohen, Cleveland.

— OSMJ —

Unveil Plaque Honoring Dr. Probst

The 25th anniversary of the dedication of the Ohio State Sanatorium, Mt. Vernon, was observed on October 29 with about 200 physicians, health commissioners, nurses and lay health workers in attendance.

One of the features of the program was the unveiling of a memorial plaque honoring the late Dr. Charles O. Probst, pioneer Ohio public health administrator. Dr. L. L. Bigelow, Columbus, delivered the presentation address.

The scientific program was presented by Dr. Kennon Dunham, Cincinnati, president of the National Tuberculosis Association and Dr. J. H. Skavlem, Dr. James N. Christenson and Dr. Cecil W. Hickam, members of the faculty, University of Cincinnati, College of Medicine.

— OSMJ —

Psychiatric Institute Held

An Institute of Post-Graduate Training in Psychiatry and Allied Branches of Medicine was held in Cincinnati the last two weeks in October and the first two weeks of November by the University of Cincinnati and the Cincinnati General Hospital, cooperating with the Longview State Hospital and the State Department of Public Welfare.

The object of the course was to establish unity and uniformity in the diagnosis, care and treatment of the mentally ill and consisted of lectures by 47 Cincinnati physicians and other experts on mental ailments.

It was arranged especially for physicians from the State Hospital.

— OSMJ —

Dr. A. L. Van Horn, formerly of the Pediatric Department, Western Reserve University, School of Medicine, and the staff of Babies and Children's Hospital, Cleveland, has been appointed chief of the Bureau of Child Hygiene, State Department of Health. The bureau has been without a director for two years because of budgetary curtailments.

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OVERPRODUCTION AND UNDEREDUCATION CHIEF CAUSES OF CRITICAL SITUATION IN FIELD OF NURSING, NATIONAL COMMITTEE SAYS

After eight years of study, the Committee on the Grading of Nursing Schools, whose membership was composed of representatives of the leading medical, public health, and nursing organizations, and augmented by prominent educators and representatives of the nurse-employing public, has released its final report, in the form of a 268-page book, entitled "Nursing Schools—Today and Tomorrow".

The Committee devoted itself to an analysis of the educational, professional, vocational, and economic problems which beset the nursing profession and proceeds in its report to unravel and suggests ways and means for their remedy and improvement.

The basic answer to the query, "What Ails Nursing", is summarized in the report in two words, "undereducation" and "overproduction".

The census of 1930 reported 288,737 women trained nurses and 5,452 men nurses. There was therefore in the United States in 1930 one woman trained nurse for every 424 persons of the general population.

At the beginning of the present century (1900) there were but 11,892 trained nurses in the United States. Since 1900 the population has increased 62 per cent, while the number of trained nurses has increased 2,374 per cent.

"The reason why nursing has grown so fast," the report states, "is that student nurses render services to the hospitals which are so valuable that, in return, the hospitals are glad to defray all their living expenses and to pay small monthly allowances in addition. Nursing is the only profession in which the student is usually maintained without cost to the family from the beginning of the first year of professional education. Naturally, the schools have had plenty of applicants, and the number of graduates has rapidly increased.

UNEMPLOYMENT NOT A NEW THING

"Unemployment in nursing was evident long before the beginning of the present economic depression. In 1926 when the Committee first began its work, there was widespread unemployment among graduate nurses. In 1927 unemployment was so serious that when 353 registries in different parts of the country were asked 'Would you like to have more nurses encouraged to move to your city?' 325, or 92 per cent, answered 'No', and many underlined the word. In 1928 and 1929, years when very few people talked about the unemployment problem, there was severe unemployment among nurses. The years from 1930 on, which brought new conditions of economic unrest to most professions, merely deepened and made more serious the problem with which nurses had for years been too familiar.

"Nurses have been unemployed in part because there are too many of them, and because there is not enough paid work to keep them busy. Inadequate preparation is a responsible factor in this situation.

"Most nurses take care of patients. The more nurses there are in a given community, the fewer patients there will be on the average for each one. The number of people per nurse is therefore an important measure of possible employment. Today there is one trained nurse for every 416 people in the United States."

It is estimated "that, on the average, about two per cent of the population is ill at any given time"; also, "that on the average there are in the United States a little less than 7 days of sickness per person per year." Of all cases, approximately 93 per cent are of such short duration that the patient is kept home from school or business two weeks or less, the report reveals.

Since there is one trained nurse to every 416 persons in the general population, and a potential need for nursing service of one day per person per year, the report points out, there ought to be, theoretically, more than enough employment for every nurse, but the situation is complicated by the addition of thousands of untrained nurses. When these untrained nurses are included there is one nurse for every 273 persons and obviously this curtails the amount of potential employment, it is said.

There are seven states (New Mexico, Oklahoma, Arkansas, Mississippi, Alabama, South Carolina and Kentucky) where there are more than 500 people per nurse, it is said, meaning that there must be many patients in those states who need nursing and cannot get it. This does not mean the report states, that there are no unemployed nurses in those states, but it does mean that if patients had the money to pay for nursing and if the nurses could reach the patients there would be no serious unemployment problem in those states.

Seventeen states (Idaho, Utah, Wyoming, North Dakota, Louisiana, South Dakota, Nebraska, Kansas, Texas, Missouri, Wisconsin, Indiana, Tennessee, West Virginia, Virginia, North Carolina and Georgia) have 300 to 500 people per nurse, so unless illnesses are rather evenly spaced throughout the year, and unless very nearly all of those

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who need nursing care are able to pay for it, there will be unemployment among nurses.

In twenty-four states there are less than 300 people per nurse, meaning unless they can find work away from the bedside, nurses must expect to be unemployed much of the time.

The Committee summarizes the situation in the following words: "In most cities and in most states there are numerically more than enough nurses." It adds, however: "There are many positions for nurses which are not adequately filled. There is no need for more graduate nurses with mediocre training and background; there is great need for nurses with broader experience, better basic professional background, and additional specialized training."

FAULTY SYSTEMS OF TRAINING

The problem of the undereducation of the nurse, the Committee found to be closely associated with that of "overproduction," and both are traceable to the same set of circumstances, namely, (1) faulty application of the apprentice system in the training of the nurse, and (2) the use of the nursing school to provide most or all of the nursing service of the hospital.

As to the nature and quality of nursing schools, of which there are no fewer than 1,583 in the United States, the report makes the following observations:

"There are three sorts of nursing schools in this country; a few very good ones, a few which are very poor, and a good many which are neither good nor poor.

"The great handicap to the advancement of nursing education has been and continues to be the lack of understanding on the part of the public that the school of nursing needs financial assistance. Money has not been supplied for the education of nurses as it has been supplied for the preparation of other types of education. Hospital resources are in almost every situation taxed to the utmost in order to carry out their primary purpose, the care of the patient. Until schools of nursing receive financial support either through private endowment or public appropriation it will not be possible for them to take their place with the schools preparing for other professions.

"There are many mediocre schools in this country. They are subordinated to the needs of the hospitals. Until these hospitals provide for their nursing service otherwise than by placing the entire burden on the student nurses, these schools will continue to be mediocre and a source of supply of poorly prepared graduates.

"There are many so-called schools of nursing which should be closed just as rapidly as the hospitals which conduct them can make arrangements for caring for their patients in another manner and for placing the students already on their rolls in other schools.

"The most serious weaknesses in schools of

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nursing are too few good teachers, too few workers, insufficient time, and not enough emphasis on what good nursing really is."

In its survey of nursing schools the Committee found that 2 per cent of the schools are controlled by universities, while most schools are controlled by hospitals, and that although in some hospitals the schools have excellent facilities and well-prepared faculties, in a large majority they are regarded as service departments of the hospital rather than as teaching institutions.

Striking to the crux of the entire matter, the Committee points out that while hospitals practically train all of the graduate nurses, they employ but a very few of their graduates in their services, using instead nursing students.

USE OF GRADUATE NURSE IN HOSPITALS

On the score of what's to be done to improve the professional quality of nursing and to alleviate economic conditions, the Committee's report states:

"Although schools should be free to experiment, they should not be free to exploit the student; nor should they produce 'nurses' whose ministrations are dangerous to patients.

"Overproduction in nursing has to be stopped. There is one way to stop it, and that is to close most of the training schools. The surest way to close the training schools is to find some other way of taking care of the patients without increasing the cost. This is the problem which the nursing profession is facing. The answer is recently becoming clear. It is coming through the voluntary action of nurses themselves. They are going back into the hospitals. The movement of graduate nurses back into the hospitals, if it continues, may mean the salvation of the profession, because it will make possible the closing of the superfluous schools. There is no hope of permanent improvement in nursing so long as the schools in the United States continue to graduate each year 25,000 or more new nurses to compete with those already in the field.

"The movement of graduate nurses back into the hospitals, replacing students and practical nurses and attendants, means better nursing for the patients. It means that the hospitals and the medical and nursing professions will think of graduate nurses, rather than of students, as the logical people to practice nursing in the hospitals.

"Most hospitals can afford to make the change because, first, part of what students now do can be carried by maids whose salaries are low; and, second, where trained nursing is required, the number of graduate nurses needed to do the work is smaller than the number of students. Money which has been spent on maintaining students—especially through the first year—can better be

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New Books Received

Allergy and Applied Immunology, Warren T. Vaughn, M.D., Richmond, Va., (Second Edition); a handbook for physician and patient on asthma, hay fever, urticaria, eczema, migraine and kindred manifestations of allergy; C. V. Mosby Company, 3523 Pine Boulevard, St. Louis, publishers; price, $5.00.

Diabetic Manual for Patients, Henry J. John, M.D., Cleveland; director of diabetic department, Cleveland Clinic; a non-technical guide for the person suffering from diabetes, including an explanation of the underlying causes of diabetes; directions for its treatment; food tables; use of insulin, etc.; C. V. Mosby Company, 3523 Pine Boulevard, St. Louis; publishers; price, $2.00.

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applied towards graduate salaries. If the movement continues for the next few years, it means that as times grow better there will be a steady demand for graduate bedside nurses. A new field will have been opened for them. They will have secured a footing in the hospitals of this country, and the nursing care of patients will be better than it has ever been before, because it will be given not by untrained or partially trained, but by fully trained, carefully selected graduate nurses."

LICENSING PLANS TO BE STUDIED

The Committee suggests that studies be made to determine whether it would be possible and desirable to provide for a system of state licenses for schools of nursing, pointing out if it were feasible to require a state license for every school which claims to prepare students to give any form of nursing care for hire, it would be far easier to establish and maintain respectable standards for nursing education.

It is also the opinion of the Grading Committee that, for the protection of the patient, the practice of all nurses should be regulated and it recommends that nurse registration for every graduate nurse be not merely permitted but definitely required in every state. It recommends that studies be made to discover whether, not only all graduate nurses, but all workers who charge money for nursing sick patients, should be licensed by the state.

Turning to the subject of courses for graduate nurses, the Committee observes that:

"There are thousands of graduate nurses who have finished training and are eager to work; yet there are patients who are either not being nursed at all or who are being inadequately nursed; and there are organization and institutional positions for nurses which are inadequately filled. There are nurses whose training has been on a sub-professional level, and whose general education would not meet the requirements for entrance to a professional school."

By way of illustration the Committee suggests as fields wherein graduate training might prove helpful, nursing of the chronic sick; nurse midwives; specialist-clinical nursing, et cetera.

The final words of the report constitute a declaration and an appeal:

"The Committee believes that fundamental improvement in nursing education is a vital essential for the health of the American people and presents perhaps the most important opportunity in the whole field of American education. We are confident that the evidence of the need for reform is unassailable and that the general lines of progress have been adequately outlined. We appeal to the nurses, the physicians, the hospital authorities, the colleges and universities, and the public to meet the challenge here presented."

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